



Health in London

Review of the London Health Strategy high level indicators

- 2005 update
- focus on the health of children and young people

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Editorial notes

1. Race and ethnicity and disability stand out as areas where there is much debate about terminology and about whether any terms or categories, including those used in official statistics (e.g. 'non-White'), can claim to be accurate, appropriate, sensitive or value free. We can only touch on the existence of this debate here. No single term is entirely adequate and none will serve all purposes, as most commentators observe. Clearly, however, some choice of terms has to be made – for example, in citing official statistics. Accordingly, a range of 'umbrella' terms is used in this publication.
2. At the time of publication the website links provided in this document were working and up to date. However, the links provided may after time become out of date, notably 'deep links' – links that are not the home page. If such link is not working then the resource you are seeking might be found by visiting the home page of the website.
3. Percentages in some tables may not add up to 100 per cent total. This is because of rounding up or down.

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Foreword

This year's *Health in London* report focuses on London's children and young people. It shows that, despite living in a city of great wealth and opportunity, not all our young people enjoy the same positive health outcomes. Many of the health inequalities faced by young Londoners reflect deep-seated problems such as poverty and unemployment.

While the overall position of London's children with regard to outcomes such as life expectancy and infant mortality is not particularly remarkable, there are other areas where performance is considerably worse than the national average. For example, rates of worklessness among households with dependent children and overcrowding impact disproportionately on London's children, particularly those living in inner London, with consequent adverse effects on their health. Rates of teenage pregnancy in the capital are higher in London than elsewhere and the trend is not encouraging, while diagnoses of sexually transmitted diseases continue to rise.

This report also highlights the significant health inequalities across different communities within London. Collective effort will be required to address these inequalities and to bring about the much needed improvements. I commend the work of the London Health Commission, who have published this report, and are bringing together a wide range of partners, through their '*Healthy Young London*' campaign, to help ensure that action to improve children and young people's health is co-ordinated across London.

And the report also shows that it is not all bad news. Educational attainment is a key determinant of health and at GCSE level continues to improve in London, and at a faster rate than nationally. Much of this progress is driven by year on year improvement in the performance of inner London pupils. In addition, young Londoners are less likely to smoke cigarettes and consume alcohol, and are more likely to consume fruit and vegetables than children and young people elsewhere.

This year's report also sets out how the various influences on children and young people's health impact at different points in their lives as well as considering the effects on those groups of children most at risk of poor health outcomes. In addition it provides a focus on the policy context in which children's services will operate in the coming years, particularly the *Every Child Matters* programme.

The report is also a timely reminder of the opportunities that winning the 2012 Olympics creates to promote children's physical activity, particularly in the light of the higher prevalence of obesity among young children in the capital compared to the national average. In addition, the Olympics should provide new opportunities to tackle some of the wider issues affecting health, including access to skills development and employment opportunities, which can offer families routes out of poverty.

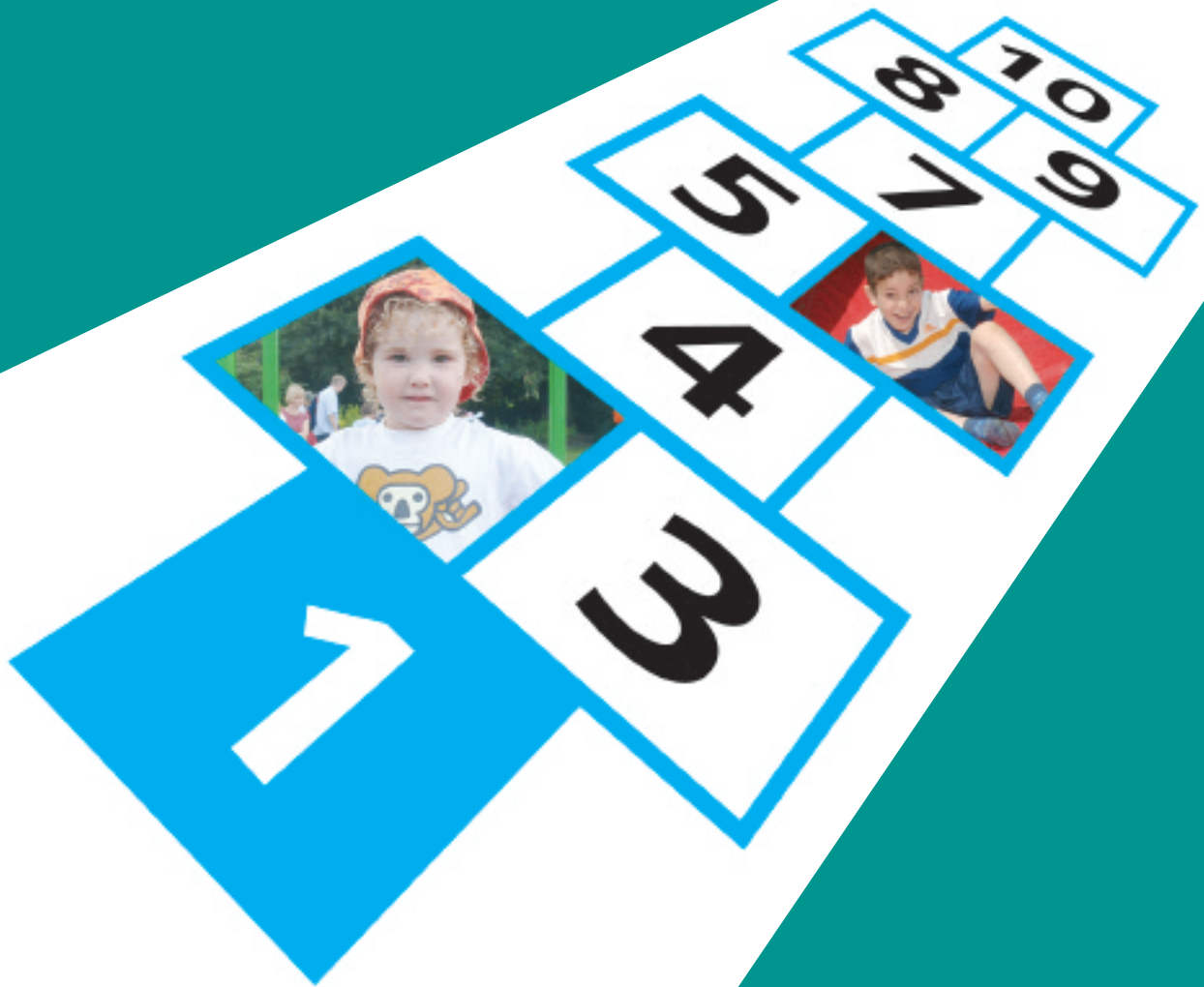
If we are to tackle the persistent inequalities in health experienced by so many of London's children we will need to harness all relevant information in order to plan and commission appropriate services. For my part, as Mayor of London, I have established a Children's Unit in the GLA to take forward my '*Children and Young People Strategy*' and I reported last year on '*The State of London's Children*'. I hope that this report will be an invaluable tool to health and local government colleagues as they look to develop their *Children's Plans*.



Ken Livingstone
Mayor of London



Introduction



In this section...

- The main aims and potential uses of this report are described, along with the context for the series of *Health in London* reports
- We highlight why a focus on children and young people is key to reducing health inequalities

Aims of the report

This is the fourth *Health in London* report. It supplements the earlier publications in the series and provides significant new information where it is available, with a particular focus on children and young people.

The aims of the report series are:

- to provide London-wide information on health and the determinants of health in a form that will support discussion and action by agencies at local, regional and national level
- to identify important inequalities in health and determinants of health in London, and to track trends in inequalities
- to highlight how diverse communities in London experience the determinants of health, indicating key areas where action is needed to reduce inequality
- where appropriate, to draw out implications for action from the report's findings.

In particular, given the raft of new policy initiatives for children and young people, a focus of this report is:

- to provide information which may be useful in the establishment of the new Children's Trusts, formulating Children and Young People's Plans and in delivering the outcomes from *Every Child Matters*.

The first report in this series (in 2002) set out the 10 high level indicators which became the framework for subsequent reports, and described why it is important to use some kind of marker to measure progress. In 2003,

the report focused on disabled Londoners, the 2004 report on London's Black and Minority Ethnic communities.

All these reports and other background information are available at www.londonhealth.gov.uk/hinl.htm. Like the earlier reports, this 2005 publication focuses on inequalities in health. The indicators chosen for this report have been selected for their particular relevance to child health.

Context for the report

The Greater London Authority (GLA) and London Health Observatory (LHO) have collaborated in preparing this report, facilitated by the London Health Commission (LHC) which publishes these reports with the Mayor of London (for further information on these bodies, please see the back cover).

The report arises from work on the London Health Strategy, developed in 1999-2000 by a partnership of regional and local agencies which identified priorities for London-wide action to improve health. Shortly after the GLA was established in May 2000, the Mayor set up the LHC to progress this work to improve the health of Londoners and reduce health inequalities across the capital. The work programme of the LHC incorporates priorities of the London Health Strategy as well as additional priority areas subsequently identified with partners. (For more information on the origins and nature of the London Health Strategy, see Section 2 of the 2002 *Health in London* report.)

The London Health Strategy has identified the high level indicators listed in Table 1. These can be used to measure

Table 1 High level indicators	
London Health Strategy – high level indicators	Relevance to Health inequalities
1 Unemployment	Associated with morbidity, injuries, poisoning and premature mortality, especially coronary heart disease. Also related to depression, anxiety, self-harm and suicide.
2 Unemployment among Black and Minority Ethnic (BME) population	As above
3 Educational attainment: percentage of pupils achieving 5 GCSE grades, A*-C	Education reduces risk of unemployment and poverty which have a negative effect on health
4 Proportion of homes judged unfit to live in	Can cause or contribute to ill health or injury and exacerbate existing conditions e.g. through damp, cold, poor design or bad lighting
5 Burglary rate per 1,000 population	The factors that affect the local crime rate also seem to affect health. Crime can also affect health directly through feeling unsafe
6 Air quality indicators – NO₂ and PM₁₀	Polluted air can damage health. The young, the elderly and those with respiratory difficulties are particularly vulnerable
7 Road traffic casualty rate per 1,000 population	Road traffic accidents are a major avoidable hazard to health, and there are large social class differences
8 Life expectancy at birth	A good summary indicator of the health status of the population
9 Infant mortality rate	The infant mortality rate is influenced by maternal health, social class and quality of care
10 Proportion of people with self-assessed good health	A good indicator of health status in adults

changes over time and to monitor progress towards reducing health inequalities. The indicators are discussed in Appendix 2 of last year's report. See <http://www.londonhealth.gov.uk/hin120>

04.htm. Section 4 reviews each indicator in London during 2004-2005, with a particular focus on children and young people where possible.

Who is the report for and how might it be used?

The report is designed for use by individuals, organisations, agencies and partnerships who have an interest in improving health and well-being and reducing inequalities. The findings provide vital information for the achievement of the government's national targets for reducing health inequalities.

At the local level, the report is likely to be useful in the following ways:

- local strategic partnerships and their member organisations, such as primary care trusts, can identify patterns of health and well-being in the geographical areas of most concern to them, and explore how their findings compare with the picture elsewhere in London
- multi-sector partnerships can use the findings to help inform their needs assessments of different populations and areas
- community and voluntary organisations can draw on the findings to identify outstanding needs and build a case for improved services
- public bodies of different kinds can draw on the report to help them work towards government targets in reducing health inequalities
- developing Children's Trusts can use the information to develop their Children and Young People's Plans and clarify the scope of the challenge involved in meeting their responsibilities associated with *Every Child Matters* and the *National Service Framework (NSF)*.

At regional and national level, agencies will be able to draw on the report in order to:

- identify pan-London trends
- track emerging issues that cross borough boundaries or affect particular populations.

In combination with past and future *Health in London* reports, it will also be possible to:

- identify trends over time.

Previous *Health in London* reports contained a series of recommendations and implications for action for policymakers and practitioners. These recommendations are being acted on in various ways. For example, the LHC has been guided by the recommendations in developing its work programme. The GLA is also incorporating recommendations in planning work in relevant policy areas. For its part, the LHO will continue to promote further work to monitor and understand causes of health inequalities.

What kinds of insights do the indicators provide?

Shedding light on the determinants of health

Many factors influence people's health and well-being. The factors which have been found to have the most significant influence – for better or worse – are known as the 'determinants of health'. While health and social services make a contribution to health, most of the key determinants of health lie outside the direct influence of health and social care, for example education, employment or housing.

The ten indicators of the London Health Strategy have been designed to highlight significant aspects of the key factors affecting health. Three of the indicators – life expectancy at birth, infant mortality rate and the proportion of people with self-assessed fair, poor or bad health – offer a means of assessing health outcomes and demonstrate how much progress we are making in London.

Highlighting areas of health inequality

Broadly speaking, there are three types of inequality in health:

- inequalities in access to, or the provision of, determinants of health
- inequalities in access to health care (for example, some groups of young people describe difficulties in accessing appropriate health care services)
- inequalities in health or health outcomes (for example, there are six years difference in average life expectancy at birth between the best and worst boroughs in London).

The high level indicators that are the subject of this report focus strongly on health outcomes and health determinants.

Further background information can be found on the LHO web site at www.lho.org.uk

Health inequalities – tackling the health gap

While policy is largely made at a national level, it is implemented regionally and locally. Narrowing inequalities in health is complex, particularly as improving health in general can sometimes result in wider inequalities, as the “better-off” are more likely to benefit from some initiatives. In order for effective changes to be made, action is needed nationally and locally; debates need to take place on the relative effectiveness of targeted and universal approaches to action, and decisions need to be made on the balance between improving overall health and narrowing inequalities.

Key policy initiatives and the reports driving them

- 1998: *Independent Enquiry into Inequalities in Health* (Acheson, 1998)
- 1999: *Saving Lives: Our Healthier Nation* (Department of Health, 1999)
- 2000: *NHS Plan* (Department of Health, 2000)
- 2000: *Local Government Act* (ODPM, 2000)
- 2002: *Securing Our Future Health: Taking a Long-term View* (HM Treasury, 2002)
- 2003: *Tackling Health Inequalities: a Programme for Action* (Department of Health, 2003)
- 2003: *Every Child Matters* (HM Treasury, 2003)
- 2004: *The Children Act* (DfES 2004)
- 2004: *Securing Good Health for the Whole Population* (HM Treasury, 2004)
- 2004: *Choosing Health: Making healthy choices easier* (Department of Health, 2004)
- 2004: *The Chief Nursing Officer's Review of the health and well-being of vulnerable children* (Department of Health, 2004)
- 2004: *The National Service Framework for Children, Young People and Maternity Services* (Department of Health/DfES, 2004)
- 2005: *Tackling Health Inequalities* (Department of Health, 2005)

The national context

In the summer of 2003, the government published a comprehensive cross-departmental action plan to tackle widespread inequalities in health across England – *Tackling Health Inequalities: a Programme for Action* (Department of Health, 2003). Since then, some progress has been made, but there is no room for complacency. *The Status Report* published in August 2005 (Department of Health, 2005) which monitored progress against the Programme for Action indicated a continuing widening of inequalities as measured by infant mortality and life expectancy. More positively, there has been progress towards reducing child poverty and a significant reduction in the proportion of households living in non-decent housing.

As *Tackling Health Inequalities* (Department of Health, 2003) demonstrates, different groups of people have very different experiences of key determinants of health, including employment, income, housing, community safety and education. These different experiences can have an effect on health. Additional dimensions of inequality for children and young people may include access to material and emotional resources, access to green space, and access to the right of protection from physical abuse by adults, including smacking, and bullying from peers and older children.

This report fits well with work being carried out nationally to identify and combat inequalities in health and the factors influencing health. The Centre for Public Health Excellence in the National Institute for Health and Clinical Excellence (NICE) will be producing public health guidance on the promotion of good health and the prevention of ill health for those working in the NHS,

local authorities and the wider public and voluntary sector.

In 1998, the *Independent Inquiry into Inequalities in Health* (Acheson, 1998) reviewed health inequalities in England, including analysis by geography, age, class, gender and ethnicity. The Acheson report made three major policy recommendations:

- Policies likely to affect health should be evaluated in terms of their impact on health inequalities
- A high priority should be given to the health of families with children
- Steps should be taken to reduce income inequalities and improve the living standards of poor households.

Children were a firm focus of this report, and the importance of tackling inequality right from the start, was emphasised. In July 1999, the White Paper *Saving Lives: Our Healthier Nation* (Department of Health, 1999) was published. It aimed to 'improve the health of everyone and the worst off in particular'. Following this, the government gave a commitment to reducing health inequalities in *The NHS Plan* (Department of Health, 2000).

New national targets for reducing the gaps in life expectancy and infant mortality were announced in February 2001 (Department of Health, 2001a). In a streamlined form, these targets appear in the Department of Health Public Service Agreement, which took effect from 2003. Life expectancy and infant mortality are included as two of the indicators in this report, which contributes to the ongoing monitoring of these outcomes for Londoners.

The importance of addressing health inequalities is actively acknowledged well

beyond the Department of Health. A Treasury-led cross-government review of health inequalities (Department of Health 2002a) considered how best to match existing resources to health need and develop a long-term strategy to narrow the health gap. Following this, in July 2003 *Tackling Health Inequalities: a Programme for Action* (Department of Health, 2003a) was launched. This sets out the cross government programme to deliver the national health inequalities targets and to make wider, more long-term progress on reducing health inequalities.

The programme proposes twelve national headline indicators to monitor progress in tackling health inequalities. These indicators are: access to primary care; accidents; child poverty; diet; education; homelessness; housing quality; influenza vaccination; PE and school sport; smoking prevalence; teenage conceptions; mortality for the major killer diseases. These indicators are supported through the adoption of local baskets of indicators to monitor progress within different areas and communities. More information on the indicators most relevant to London can be found on the LHO website http://www.lho.org.uk/Health_Inequalities/BasketOfIndicators/BasketIndicators.htm

The programme acknowledges that health inequalities are stubborn, persistent and difficult to change. Accordingly, there is emphasis on creating movement in the following key areas:

- reversing the inverse care law – whereby people with the greatest need tend to have poor access to quality services
- getting a better balance between treatment and prevention

- creating an environment where families and communities have the chance to lead longer and healthier lives.

So, what does it look like in practice? The programme is organised around four themes, all of them requiring action at both national and local level:

- **supporting families, mothers and children** – to ensure the best possible start in life and break the inter-generational cycle of ill-health
- **engaging communities and individuals** – to ensure the relevant, responsiveness and sustainability of initiatives
- **preventing illness and providing effective treatment and care** – to ensure that the NHS provides leadership and makes the contribution to reducing inequalities that is expected of it
- **addressing the underlying determinants of health** – to deal with the long-term underlying causes of ill-health.

The ‘framework for action’ at the heart of the programme is summarised in Figure 1 and illustrates the need to tackle inequalities in practice by preventing health inequalities getting worse, making mainstream services more responsive to the needs of disadvantaged populations, targeting some interventions, supporting action at a national level through the management of clear policies, and meeting national standards locally.

Further evidence to support the *Programme for Action* emerged from the Wanless report on NHS spending, *Securing Our Future Health: Taking a*

Long-term View (HM Treasury, 2002). This independent review was the first ever evidence-based assessment of the long-term resource requirements for the NHS. Following this, a further review, *Securing Good Health for the Whole Population* (HM Treasury, 2004), was carried out. It examines how public health spending decisions are taken, and how to ensure that they are cost-effective and consistent in order to improve health outcomes.

In 2004, following a major public consultation, the government published a White Paper on public health, *Choosing Health: Making healthy choices easier* (Department of Health 2004b). This sets out the need for action to encourage healthy choices and promote health for all.

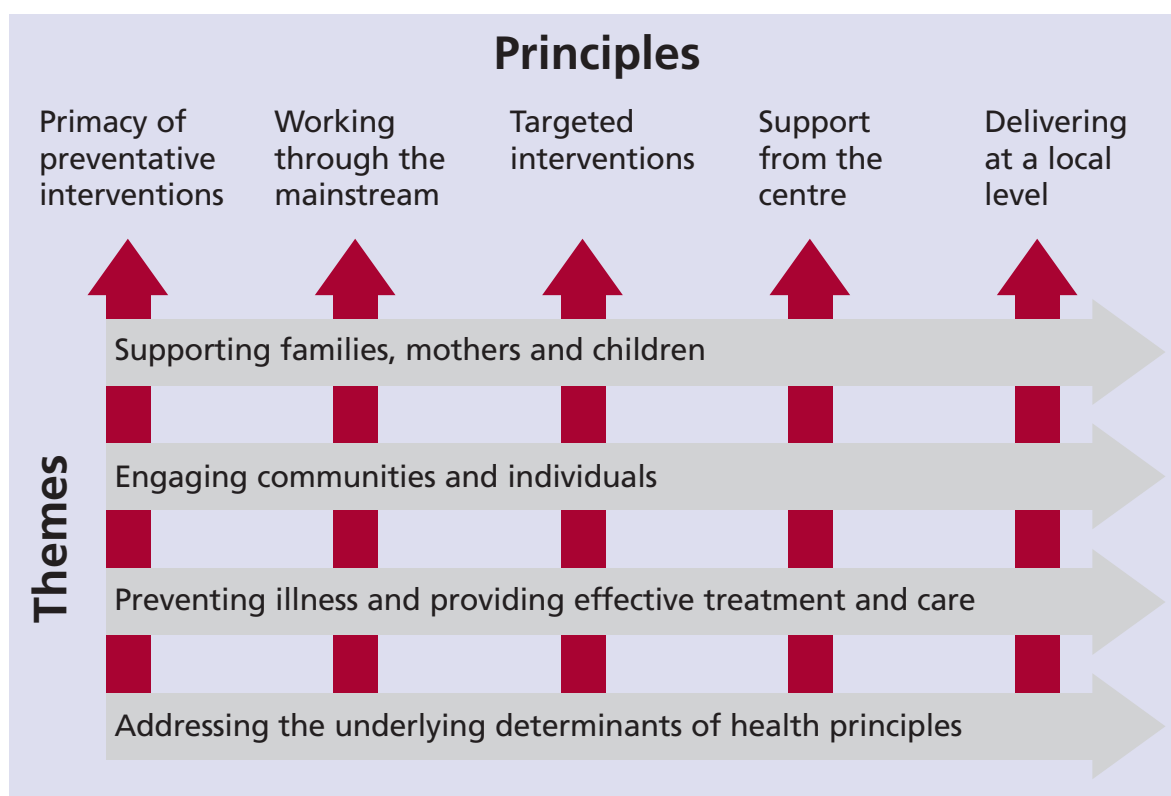
Choosing Health is just one of a range of policy initiatives focused on promoting the health and well-being of children and young people. Other significant developments include:

- *The Chief Nursing Officer's Review of the health and well-being of vulnerable children* (Department of Health, 2004a)
- *Every Child Matters* (HM Treasury, 2003)
- *The National Service Framework for Children, Young People and Maternity Services*. (Department of Health/DfES, 2004)

The London context

The London context holds both promise and a degree of anxiety for London's children. The announcement in July 2005 of London as host to the 2012 Olympic games presages new developments, new employment opportunities, and new opportunities for children and young people to participate in sport. Terrorist activities in the same month inevitably bring with them anxiety for children and young people, and for some, increased exposure to racism and Islamophobia.

Figure 1 *Health Inequalities Programme for Action*



Choosing Health priorities

- Reducing the number of people who smoke
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible drinking
- Improving sexual health
- Improving mental health

London is estimated to be home to well over 7 million people and this is projected to grow by another 810,000 by the year 2016 – equivalent to adding a whole new city to London's existing population. The profile of the population will continue to change, as it has throughout the city's history. In particular, changes in age and ethnicity are projected so that, for example, by 2016 London's working age population will have grown by 516,000 and of these 80 per cent are likely to be from Black and Minority Ethnic communities (GLA, 2004a, Feb). The age profile of London is a little younger than the UK average. In particular, we have more 0-4 year olds in London than elsewhere. For further information see <http://www.statistics.gov.uk/census2001/pyramids/pages/H.asp>

London is a culturally diverse city, with one in three Londoners coming from an ethnic minority community, and over 300 languages being spoken. This diversity is one of the features that makes London such a vibrant world city – yet we know that London's communities do not benefit in equal measure from the opportunities and wealth the capital has to offer.

London is characterised by marked contrasts between affluence and poverty. In 2003, London's GDP was estimated to be £180 billion, with 375 of the top 500 global companies having offices here, cultural and creative industries generating an annual turnover of £25-29 billion, and visitors spending approximately £15 billion in total. The London economy contributes around 17 per cent of the UK's total GDP and is comparable in size to those of Sweden, Belgium and Russia. However, Greater London also has 20 of the 88 poorest local authorities in the UK, and there continues to be a spatial distribution of disadvantage, with a greater concentration of deprived wards being in inner London. One in three older people and 43% of children in Greater London are estimated to be living below the UK poverty line, and most minority groups continue to experience high levels of unemployment and child poverty (GLA, 2002, Nov). The challenge in London is twofold:

- more effectively understanding and tackling existing inequalities
- working together to ensure that growth over coming years does not result in an even greater divide between those best and worst off.

The LHC and partner organisations all have important London-wide roles to play in meeting these challenges. See Appendix for details of LHC members and partner organisations.

The local context

London boroughs have clear responsibilities for addressing the well-being of the local community. The *Local Government Act 2000* introduced a general power to take action to promote economic, social and environmental well-being of their areas. The *Health and Social Care Act 2012* provided additional health scrutiny powers (for information on these, see Democratic Health Network, 2002). The boroughs work through their programmes, including education, housing, community safety, social services and environment, often in partnership with statutory and voluntary sector agencies.

NHS services come together at local level through Primary Care Trusts (PCTs), which work within the same boundaries as local authorities in London. PCTs are responsible for improving and protecting the health of their populations, and for reducing health inequalities within those populations. Specific responsibilities include:

- ensuring delivery of primary care services (for example, those health services provided by GPs, community nurses and midwives, pharmacists or therapists)
- commissioning hospital and mental health services
- developing and implementing local delivery plans, in accordance with the NHS planning and priorities framework.

The NHS planning and priorities framework highlights the health equity

audit as a tool for focusing work on tackling inequalities in health. The health equity audit involves reviewing in a systematic way, within defined populations, inequalities in:

- the causes of ill-health
- access to effective health services and their outcomes.

Audits of this kind can generate actions for local services and plans, and therefore can usefully shape the evaluation of work by the NHS and other partners to reduce health inequalities.

In short, they can be used to:

- inform the commissioning of services
- contribute to local performance management
- support partnership working, and the distribution of resources
- encourage community involvement.

A particular impetus has been given to action at a local level to reduce inequalities in health by the *Public Service Agreement* targets agreed in the *2004 Spending Review*. The Government set a *Public Service Agreement* target to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases. The targets aim to see faster progress, compared to the average, in the “fifth of areas with the worst health and deprivation indicators”.

The local authorities and Primary Care Trusts which are in these areas are collectively known as the Spearhead Group, which is made up of 70 local authorities and 88 Primary Care Trusts. It is based upon the local authority areas that are in the bottom fifth nationally for

three or more of the following five indicators:

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Cardiovascular disease mortality rate in under 75s
- Index of multiple deprivation 2004 average score.

London members of the Spearhead Group are Hammersmith and Fulham, Haringey, Islington, Barking and Dagenham, Hackney, Newham, Tower Hamlets, Greenwich, Lambeth, Lewisham and Southwark.

The voluntary and community sectors in London have been shown to add considerable value to the design, planning and delivery of public services, with the voluntary sector for children and young people playing a particularly important role in developing and delivering services to marginalised groups (GLA, 2005).

Increasingly, different sectors work together through regeneration and local strategic partnerships. These can be particularly valuable in creating employment and training opportunities, strengthening joint work and tackling health concerns. *Every Child Matters (ECM)* put a premium on these partnerships and for this reason, our report this year also refers in particular to the *Every Child Matters Outcomes Framework* for children.

The development of *Children's Trusts* aims to achieve joined-up services that place the needs of children and families at the centre of their approach to

planning, commissioning and, ultimately, delivering better outcomes. This provides particular opportunities for different sectors to work together, thus forming stronger and more co-ordinated services for children and young people in an area, underpinned by the *Children Act 2004* duty to cooperate.

Further, *Children's Trusts* will support those who work every day with children, young people and their families to deliver better outcomes – with children and young people experiencing more integrated and responsive services, and specialist support embedded in and accessed through universal services. People will work in effective multi-disciplinary teams, be trained jointly to tackle cultural and professional divides, use a designated lead professional where many disciplines are involved and be co-located, often in extended schools or children's centres. *Children's Trusts* will be supported by integrated processes. Some processes, like the *Common Assessment Framework*, will be centrally driven, whereas others will be specified at a local level. Pathfinders in London are currently in Bexley, Croydon, Ealing, Greenwich, Hammersmith and Fulham, Redbridge, Sutton and Tower Hamlets.

In London this year, 15 *Local Area Agreements* (LAA) are being developed by local authority-led partnerships. One block of each LAA must describe how improving local services will lead to better outcomes for children and young people. Another block addresses community safety, with strong links to young peoples' issues.

Community plans and partnerships can provide the context for tackling inequalities and promoting social inclusion, providing a focus for action at neighbourhood or community level. Local authority overview and scrutiny

committees can undertake scrutiny of health and health services in their area, which provides opportunities for local investigation of key issues and the generation of recommendations for service improvements to meet local need.

Overall, local councils, health and social care services, community and voluntary organisations all have an important part to play in improving the health and well-being of Londoners and improving child public health and the health of the wider community. The challenge is to identify and make best use of the expertise, experience and opportunities each sector brings to this area of work, and to demonstrate the relevance of the health inequalities agenda to their core business and responsibilities.

The *Health in London* reports attempt to deepen understanding of many of these dimensions in London. This report updates key information on a range of inequality dimensions for children and young people in London.

Focus on children and young people



In this section...

- Current developments in the policy and service context are discussed
- What is a child? A note on terminology
- Influences on the health of children and young people are described including the key determinants of the health of children and young people in relation to different life stages
- The health of specific groups of children and young people is discussed with a focus on excluded or vulnerable groups
- Specific health concerns for children and young people are explored including what children and young people themselves say about health inequalities

Introduction

Over the last century, the health of children in the UK has improved overall. Nevertheless, there remain major health challenges in reducing inequalities in child health, improving the access of the most vulnerable children to health resources and ensuring that those children who do live with major health problems are able to be all they can be.

Health matters to children, families and communities. Although the media attention given to hospital closures, waiting lists and the like might suggest that 'health' is synonymous with health services, what makes a real difference to health are those things which determine it where many opportunities for change lie beyond the scope of the NHS. In the UK there are large social class, ethnic and other differences in life chances related to health. Children born into poverty and disadvantage miss out on important opportunities for health gain, and accumulate health risks as they grow into adulthood.

This 2005 Health of London report has a special focus on children and young people. This is timely, given the appointment in summer 2005 of the first Children's Commissioner for England, and current policy and practice changes driven by the Children Act 2004, the *Every Child Matters (ECM)* programme and the *National Service Framework for Children, Young People and Maternity Services*. These changes present a major opportunity for all organisations concerned with children and young people to work together to improve outcomes, including the health outcomes so fundamental to children's lives now and in adulthood.

What is a child? A note on terminology

Just as last year's report touched on issues of terminology associated with race and ethnicity, there are also definitional problems relating to children and young people. When does a 'child' become a 'young person' and when does a young person become an adult?

A young person may instruct a lawyer in a criminal case at 10, marry at 16 (though not adopt a child until 21), and join the army at 16. In a health context, 16-18 year olds will normally be asked to consent to treatment or examination on their own behalf. Before then, it will depend on the young person's ability to understand what is involved, (Department of Health, 2001).

Increasingly, even very young children will be asked for a view by those working in health and social care. Those under 16 have the same rights to confidentiality as adults when seeking contraceptive advice. And of course, children and young people themselves have different views on what constitutes a child: most 15 year olds, for example, do not think of themselves as 'children'.

The legal definition of a 'child' in the UK is a person under the age of 18 years. In practice, however, there is a range of working definitions of child and young person across agencies. For example, youth services often work with 'young people' up to the age of 25; some young people in receipt of services including disabled young people or care-leavers may remain eligible for support beyond the age of 18. This results in data being collected and reported differently. Clearly, however, some choice of terms has to be made – for example, in citing official statistics. Accordingly, a range of 'umbrella' terms is used in this publication, and

much of our data are dependent on age categories used for classification purposes by a range of agencies. Not all of these categories are consistent.

For the purposes of this report, we use the term 'children' to encompass younger children up to 12; 'young people' to describe 13-17 year olds; 'young adults' to describe over 18s. We use the generic term 'children and young people' to encompass all these groups. Where possible we specify the age ranges to which any reported data apply.

Current policy for children and young people

The policy context for children and young people has undergone significant and rapid change in the last year. *The Children Act 2004* provides the legislative basis for the ECM programme and the reform of children's services. The key provisions of the *Children Act* are:

- The appointment of a Children's Commissioner to champion the views and interests of children and young people
- A duty on local authorities to make arrangements to promote co-operation between agencies and other appropriate bodies to improve children's well-being and a duty on key partners to take part in the co-operation
- A duty on key agencies to safeguard and promote the welfare of children
- The establishment of Local Safeguarding Children Boards
- Provision for databases of basic information about children and young people to facilitate better sharing of information between agencies
- A requirement for a single *Children and Young People's Plan* (CYPP) to be drawn up by each local authority
- The appointment by local authorities of a Director of Children's Services and a designated Lead Member
- The creation of an integrated inspection framework and the conduct of *Joint Area Reviews* to assess local progress in improving outcomes
- Provisions relating to foster care, private fostering and the education of 'looked after' children.

ECM sets out a framework for radical change in the system of children's services to improve outcomes for all children and young people. The five outcomes are:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being.

These outcomes are the basis for a framework of performance targets to be delivered through an integrated approach to children's services, including health, education, social care, housing and regeneration and the voluntary and community sector. Improving the health of children and young people is a vital component of achieving these.

Measures to improve health and reduce child health inequalities not only contribute directly to the 'be healthy' and 'stay safe' outcomes, but indirectly to the others: poor health is a significant

barrier to educational achievement, enjoyment and economic well-being. Improving the health of children and young people is therefore a key objective of all organisations involved in local strategic partnerships for children and young people.

In achieving these priority outcomes, the emphasis is on an integrated approach to strategic planning, commissioning and service delivery. There is a requirement to bring together provision for children and young people in each local authority area in partnership arrangements which in most areas is leading to the establishment of *Children's Trusts*. Other key elements of the integration agenda are:

- The *Common Assessment Framework*
- Information sharing
- An integrated children's workforce strategy with common core competencies for those working with children.

The ECM programme provides opportunities for health organisations to work in partnership with others to improve outcomes for children and young people generally and to keep the health of children and young people high on the agenda.

In particular there is a strong emphasis on: early identification and intervention; strengthening health promotion in local communities; targeting resources to those areas in greatest need; involving children, young people and families in decisions. Further details of ECM can be found at <http://www.everychildmatters.gov.uk/>.

The National Service Framework (NSF) is an integral part of the *Change for*

Children programme. The NSF is composed of 11 sets of standards on:

1. Promoting health and well-being, identifying needs and intervening early
2. Supporting parents and carers
3. Child, young person and family-centred services
4. Growing up into adulthood
5. Safeguarding and promoting the welfare of children and young people
6. Children and young people who are ill
7. Children in hospital
8. Disabled children and those with complex health needs
9. The mental health and psychological well-being of children and young people
10. Medicine management for children
11. Maternity services.

There are four underlying themes of the NSF which are also reflected in ECM:

- A focus on health promotion and healthy lifestyles as well as managing illness and complex needs
- A recognition of the need to address inequalities
- A recognition of the particular needs of children at risk of poor outcome
- An emphasis on promoting the safeguarding of children and young people.

In the remainder of this section we consider the main factors of relevance to these themes, in particular the factors underpinning child health inequalities.

Child health inequalities

Much of the thinking behind current policy initiatives to improve health outcomes and reduce child health inequalities can be traced back to the *Independent Inquiry into Inequalities in Health* chaired by Sir Donald Acheson and published in 1998. A key message in this report was that the action to reduce child health inequalities needs to be taken on broad fronts and not only in 'medical' settings. Despite the fact that the inquiry was chaired by one of the country's most senior doctors, reporting to the Secretary of State for Health, most of what was recommended was not a task for the National Health Service. There is no vaccine against poverty. Effective remedies involve tax and benefits, education, employment, housing, the environment, transport and pollution (Curtis and Roberts, 2004).

Of the recommendations in the Acheson report, ten were, and remain, of particular relevance in reducing health inequalities for children and young people:

- reductions in poverty in women of childbearing age, expectant mothers, young children and older people by increasing benefits in cash or kind
- the development of high quality pre-school education so that it meets, in particular, the needs of disadvantaged families
- measures to encourage walking and cycling and the separation of pedestrians and cyclists from motor vehicles
- policies which reduce poverty in families with children by promoting material support; removing barriers to work for parents who wish to combine work with parenting; and

enabling those who want to be full-time parents to do so

- an integrated policy for the provision of affordable, high quality day care and pre-school education with extra resources for disadvantaged communities
- policies which improve the health and nutrition of women of childbearing age and their children, prioritising the elimination of food poverty and the prevention and reduction of obesity
- policies which increase breastfeeding
- policies which promote social and emotional support for parents and children
- consideration of minority ethnic groups in needs assessment, resource allocation, health care planning and provision
- policies which reduce psychosocial ill health in young women in disadvantaged circumstances, particularly those caring for young children.

Subsequent policy developments, summarised in the introduction to this report, have sought to address the above issues and significant progress has been made. However, the health gap between the 'best-off' and 'worst-off' children and young people remains too wide and much more needs to be done if the vision for children's well-being set out in ECM is to be achieved.

Influences on the health of children and young people

It will be evident from the above that health and wealth are strongly related,

and that in order to reduce inequalities in health, we need to address the determinants.

We have set out the various influences on the health of children and young people beneath one overarching influence – poverty – and then describe some of the influences at different points in the child or young person's life. Parents clearly play a large part in the well being of their children; we suggest here the need to affirm the heroic efforts most parents living in poverty make to protect the health and well-being of their children. We also raise in this section the relationship between ethnicity and health, whilst sounding a note of caution that the relationship is not straightforward.

Starting with **Early life**, we describe next some of the maternal and family influences, including breastfeeding on the positive side, and smoking as a negative influence; in **Middle and later childhood, and adolescence** important influences include emotional well-being and nutrition. Finally, in **Health behaviours in adolescence**, the influence of, and influences on, sexual behaviour are described.

Poverty

A major influence on outcomes for children is poverty. Roberts' (2000) summary highlights the strong link between health and wealth, with children born into poverty more likely than their better-off neighbours to:

- die in the first year of life
- be born small, be born early, or both
- be bottle fed
- die from an accident in childhood

- smoke and have a parent who smokes
- have poor nutrition
- become a lone parent
- have or father children younger
- die younger.

Despite improved obstetric and neonatal care, babies born early, and babies born small are at risk of a range of poor outcomes both immediately and in later life. Having a premature or very small baby also means an anxious start to parenthood.

As summarised above, children born into poverty are more likely than better-off children to be born small, be born early, or both (MacFarlane and Mugford, 2000), to be bottle fed (Garcia et al, 2000), have a parent who smokes and in due course, become a smoker (Jarvis et al, 2000) and have or father a child sooner than they would like to (CRD, 1997). Moreover a child in the lowest social class is twice as likely to die before the age of 15 as a child in the highest social class (Botting, 1995).

At the national level, infant mortality rates have more than halved since the mid 1970s, but babies with fathers in manual jobs are still more likely to die than those of men in non-manual occupations. The differential was particularly marked for babies with fathers in partly skilled or unskilled occupations. Inequalities around infant mortality are more pronounced when a baby is aged over one month, compared with the first month of life. On average, babies of teenage mothers are at greater risk of infant mortality than those born to women in their forties.

Parenting

Mothers – usually the main caretakers of children – and parents in general are frequently a focus of criticism. This may be implied through, for example, the proliferation of parenting courses, or explicit, with the suggestion that the main need for change lies at their door. This is despite evidence that the vast majority of mothers living in poverty bring up their children successfully, and protect and promote their health in unpromising conditions (Blackburn 1992; Roberts et al, 1995; Kempson 1996). The harm which can be done by failing to affirm the majority of good mothers, and failing to recognise the barriers and obstacles to good mothering, sometimes invisible to professionals, cannot be underestimated. The phrase ‘It’s like teaching your children to swim in a pool full of alligators’ (Rice et al, 1994) is all too true of the conditions faced by many families.

None of this is new. In the early 1940s, Richard Titmuss’ *Birth, Poverty and Wealth* (Titmuss, 1943) showed that children’s deaths were related to the occupations of their fathers, and that the gap between the life chances of working class and middle class infants had increased since 1914. Newspapers of the time reported ‘Poor folks’ babies stand less chance’, and ‘Babies beware of poor parents’. A reviewer for the *Evening Citizen* suggested that the book ignored ‘the criminal ignorance and neglect of many mothers’, who were inclined to give their babies ‘fish and chips, pickles, strong tea, lollipops, chocolate biscuits and toffee apples’ (Oakley, 1996:190). In 2000, a reviewer of the BMA’s *Growing up in Britain* asked ‘Why do children from poor families consume such a lot of sweets, fizzy drinks, milk and white bread?’ suggesting a plausible answer: ‘Penny for penny, a chocolate bar provides more

calories than carrots, even from a market stall’ (Thurlbeck, 2000:809).

Ethnicity

Minority Ethnic children and young people are not, of course, a homogeneous group. Some will have better health than white British young people, some worse. Some will have better health behaviours in relation to smoking and alcohol, some worse. However, children and young people from minority ethnic groups are subject to inequalities in health for a number of reasons.

Firstly, there is an association between ethnicity and poverty. It is well documented that socio-economic status is a significant contributing factor to ethnic variations in health and is linked to higher rates of chronic illness in the most disadvantaged ethnic minority communities (Nazroo, 1997). National data suggests that more than half of African Caribbean children live in areas of high unemployment, and that Bangladeshi and Pakistani children are consistently amongst the poorest of the poor with a higher proportion of these groups living in deprived neighbourhoods and in poor housing (Arora et al, 2000).

Secondly, children and young people from minority ethnic groups suffer both individual and institutional racism. Racism is a reality in the UK today, as suggested by Nazroo’s 1997 study in which around a quarter of white people interviewed admitted to racist feelings against black and Asian groups. Racism contributes to a climate of anxiety and fear which can directly impact on the health and emotional well-being of children and young people. Institutional racism may be a contributory factor in increasing inequalities in access to health care provision.

This can play out in a variety of ways: in stereotypical assumptions about South Asian families not requiring health care because 'they look after their own', to beliefs about African and Caribbean cultures being threatening or in need of control (Ahmed & Atkin, 1996) or a colour blind approach to service provision which fails to meet the specific needs of ethnic minority communities in a misguided attempt to 'treat everyone the same' (Alexander, 1999). Nazroo (1997) and Karlsen & Nazroo (2002) argue that poverty and racism play a greater role than cultural differences in health inequality: social disadvantage plays a key role in determining ethnic inequalities in health; while health differences cannot be understood just by knowing someone's ethnic group.

Data from the *2001 Census* provide some information about the associations between health status and ethnicity. Based on parental reports, Census data show that the highest proportion of parents reporting good general health of their children were parents of white children (91%) and African children (92%) with the lowest being parents of Caribbean (85%), Pakistani (86%) and Bangladeshi (86%) children (ONS, 2003).

Early life

This developmental stage is critical for the brain development and mental health of children. Secure attachment to the mother confers an ability to manage feelings and to cope with difficulties encountered in life. In addition, secure attachment to the father influences the child's ability to function well in relationships with others as well as improved educational attainment. Secure attachment may be disrupted by poor housing conditions, demanding work patterns or by post-natal depression (in either the mother or the father).

Breastfeeding

Breastfeeding is a key determinant of the health, development and emotional wellbeing of infants, and of long-term health gains extending into adulthood, yet there are marked socioeconomic, ethnic and regional differences in starting to breastfeed, and keeping it up. These differences can contribute to both initial and persistent inequalities in health.

Breastfeeding is associated with a number of benefits to children, and can be a source of pleasure to mothers (Thompson and Westreich, 1989). It is cheap and convenient and is associated with lower rates of infection, and lower rates of sudden infant death. Around two thirds of babies in the UK have some breastfeeding.

Despite efforts to encourage breastfeeding, there are strong social class differences in breastfeeding. National breastfeeding statistics hide considerable differences relating to the age and educational status of the mother, the social group to which she belongs and the geographical area in which she lives (Hamlyn et al, 2002).

- Mothers in manual social class groups are less likely to breastfeed than those in non-manual groups (63% as opposed to 83% at birth) – only 13% of babies whose mothers were classified in the 'lower occupations' group are receiving any breastmilk at six months, compared with 31% in the 'higher occupations' group
- Mothers who remained in full-time education until they were 18 are more than three times more likely to breastfeed their babies to 4-6 months of age than mothers who left school aged 16 or under
- More than three quarters of mothers

aged 30 or over breastfeed their babies compared with less than half of mothers aged 20 or under.

Smoking

Smoking during pregnancy is associated with low birthweight in babies. In addition, about 41% of British children are exposed to environmental tobacco smoke. This increases children's susceptibility to respiratory tract infections, ear problems, asthma and Sudden Infant Death Syndrome (Hovell et al, 2000). Exposure to passive smoking among children in England has approximately halved since the late 1980s. This reduction is mainly accounted for by reductions in exposure in children from non-smoking homes, and a fall in the percentage of parents smoking (Jarvis et al, 2000).

Nutrition

Research indicates that nutrition in foetal life and the very early months may critically influence adult behaviour and learning (Barker 1994). While a number of interventions have been developed in promoting healthy diets as well as changes to drinking and smoking patterns during pregnancy, these have met with varying degrees of success. We do not yet know the true impact of maternal nutrition on foetal development. Even famine conditions produce surprising small effects on foetal growth (BMA, 1999).

Folic acid supplements around the time of conception for women at increased risk of having a child with neural tube defects (NTD) reduce the risk of recurrence by more than two thirds (Enkin et al, 1995). Clearly, unplanned pregnancies are a challenge in this respect.

A good diet for the mother, and a well-fed infancy and childhood are vital, and all children (and adults) have a right to a decent diet, irrespective of their current or future parental status.

Middle and later childhood, and adolescence

An important causes of death and disability in middle and later childhood, adolescence and young adulthood is injury on the road. On the more positive side, play and play spaces discussed below, can have a positive effect.

Injury and illness

After the first year of life, the most common causes of death in childhood are external causes including injury, poisoning and cancers (ONS, 2004). The mortality rate for childhood cancer has continued to decline with around 70% of children now successfully treated (Cancer Research UK, 2003).

Accidents

Relevant studies have demonstrated the following key points:

- The social, geographical and gender patterning of accidents suggests that accidents are not a matter of chance
- Children from poor background are far more likely to be killed in an accident than their "better-off" neighbours
- Boys are at greater risk of accidents than girls
- Some areas of the country, largely those with significant areas of deprivation, have high accident rates
- Children in poor housing, including bed and breakfast accommodation, are at greater risk
- Children from large families, or families where there is only one parent to supervise are more likely to be involved in an accident

- Child pedestrians are more at risk than children transported in cars. Car transport for some children increases the risk to others.

Deaths from accidents have also steadily declined, but there are major social class variations associated with deaths due to injury (Towner, 2002). The rate of deaths by fire is 15 times higher for children in the lowest groups than for the highest socio-economic groups. The most disadvantaged children are five times more likely to die as a child pedestrian.

Whilst these deaths are relatively rare, it has been estimated that for every death due to injury there are numerous non-fatal accidents causing injury (Conway & Morgan, 2001). Children in lower-income and lone parent households are more likely than other children to sustain injuries requiring a visit to a doctor or a hospital (Department of Health, 2003).

If parents and children do not have confidence in the safety of spaces for outdoor activities, it is harder for parents to support their children in the task of growing independence and managing risk – this leaves children more vulnerable to accidents.

Mental health and positive emotional well-being

At a national level, mortality rates for adolescents from injury and suicide have increased fivefold over the last century – rising from 11% of total deaths for 15-19 year olds in 1901-10, to 57% in 2003. Rising suicide rates among young men, and an increase in mental health problems in children and young people indicate a need to focus on improving social and emotional health. Mental health is more profoundly affected by socio-economic factors than many other dimensions of health (Carr-Hill et al,

1994). Mental health of parents is also an important determinant of children and young people's health and well-being.

Self-harm

Deliberate self-harm is a term used when someone injures or harms themselves on purpose. Common examples include 'overdosing' (self-poisoning), hitting, cutting or burning oneself. It can also include taking illegal drugs and excessive amounts of alcohol. According to the Royal College of Psychiatrists, self-harm is always a sign of something being seriously wrong.

The Royal College's factsheet on self-harm gives some of the reasons young people provide for injuring themselves:

- Some say that they have been feeling desperate about a problem and don't know where to turn for help. They feel trapped and helpless. Self-injury helps them to feel more in control.
- Some people talk of feelings of anger or tension that get bottled up inside, until they feel like exploding. Self-injury helps to relieve the tension that they feel.
- Feelings of guilt or shame may also become unbearable. Self-harm is way of punishing oneself.
- Some people try to cope with very upsetting experiences, such as trauma or abuse, by convincing themselves that the upsetting event(s) never happened. These people sometimes suffer from feelings of 'numbness' or 'deadness'. They say that they feel detached from the world and their bodies, and that self-injury is a way of feeling more connected and alive.

Bullying

Bullying is a factor which appears to be related to poor self-esteem and is certainly associated with misery for those children unfortunate enough to experience it. Research has demonstrated the extent of bullying and a recent report suggests that homophobic bullying may be a particular problem, and one related to self-harm. One UK study found that more than 50% of lesbian, gay and bisexual women and men who had been bullied at school reported having contemplated self-harm or suicide; 40% had made at least one attempt to self-harm, and three quarters of those made subsequent attempts (Rivers, 2001).

Play

One way of promoting better health is through play (Mayor of London, 2004) – a key part of the Mayor's strategy for children and young people.

A practical tool to assist local boroughs to meet the play and leisure needs of children and young people living in London is the *Mayor's Guide to Preparing Play Strategies – Planning inclusive play spaces and opportunities for all London's children and young people* (2005). It sets out the basis for providing children with accessible spaces offering free, high quality, inclusive play opportunities throughout their environment – a need commonly identified by parents/carers as well as children and young people.

Developed by London Play on behalf of the Mayor of London, this guidance is a companion document to the Mayor's *Guide to Preparing Open Space Strategies*. It is also part of the Mayor's policy (London Plan, 3D.7) to work with strategic partners to protect and promote London's network of open spaces, and realise their value for communities and protect their many benefits, including children's play.

During consultation by the Mayor, children were asked their advice on making London a better place for children to play.

- Make sure there's at least one park in every estate. Make it safe
- Keep London tidy
- Make big toys cheap
- Make streets where children can play
- Free access to leisure centres
- Better football grounds, swings and playgrounds
- More activities after school. Closer activities to school. New things like different playgrounds
- More ramps and pools
- More parks, fewer cars
- Larger play areas
- No bad people, more parks
- More benches to hang out with my friends.

Some of the ways by which the health of children and young people might be improved are listed in the box below.

A better place for children and young people

- Provision for teens – free and affordable leisure facilities, hang out areas/skate parks etc. A lot of the issues will be addressed through the *Youth Green Paper*; the *White Paper* must make links to planning in order to deliver services that meet needs.
- Emphasis on inclusive play. In London, as across the UK, there is evidence that disabled children do not enjoy equality of access to play and leisure facilities.
- Quality play and leisure provision within nurseries, schools and colleges to inspire creative learning and more physical activity.
- The importance of innovative

designs aspects of play spaces and play equipment – with children and young people involved as much as possible – to build in risk and challenge at a design stage without compromising safety.

- Highlighting the new statutory status of recreation in ECM in order that it is 'not sidelined' by other priorities.
- More guidance on play in schools and on improving school grounds.
- Opportunity to deliver more play and leisure through the *Building Schools for Future* programme.

Health behaviours in adolescence

Many adolescents in the UK are at the peak of their health, and it would be a mistake to stigmatise them in terms of their health behaviours. However, there are some causes for concern. A BMA publication on the health needs of adolescents reported that problems include overweight, smoking, psychological problems, sexually transmitted diseases, early conception, poor intake of fruit and vegetables and drug use (BMA, 2003).

Information available from health surveys (such as the *Health Behaviour of School-aged Children* (HBSC) survey – see <http://www.hbsc.org/overview.html>) provides some trend data on lifestyle factors relating to health.

Alcohol and smoking

Nationally, key trends show the proportion of young people drinking alcohol increasing with age, particularly among boys.

An area of concern is the proportion of young people 'binge drinking' which presents health risks both in its own right and because of its association with risky behaviour. The prevalence of smoking varies between regions of the

UK and there are gender differences, with girls being more likely to smoke than boys.

Sexual health

Sexual health is about more than avoiding getting pregnant or having a sexually transmitted infection. However, we highlight these aspects of sexual health in this report because they are areas where bringing about change is likely to affect the health of children and young people not only immediately, but in the longer term as well.

Conception and birth rates in the UK are the highest in Europe and second only to the United States in the developed world. While by no means all teenage pregnancies are unplanned or unwanted, there is a strong association between poor outcomes and having (as well as being) a teenage parent.

Pregnancy

Compared with their peers in more affluent areas, young women in poorer areas of the UK are more likely to conceive (Coleman and Schofield, 2001), less likely to have abortions and more likely to give birth (SEU, 1999). Socially excluded teenagers in these settings are particularly at risk – for example, those excluded from school (Allred, David and Smith, 2002), those 'looked after' by local authorities (Corlyon and McGuire, 1997) and those in contact with the criminal justice system (SEU, 1999).

Sexually transmitted infections

The Department of Health's *National Strategy for Sexual Health and HIV* indicates that the most common conditions now at a national level are chlamydia, non-specific urethritis and wart virus infections, but almost all sexually transmitted infections (STIs) are becoming more common. The number of visits to departments of genito-urinary

medicine (GUM) in England has doubled over the last decade and now stands at over a million a year. Diagnoses of genital chlamydia also almost doubled during the 1990s, with a particularly marked increase in men and women aged under 20. Recent surveys of women indicate chlamydia infection rates of up to 12% and there are more reports of outbreaks of syphilis.

Teenagers and young adults bear much of the burden of disease (Department of Health (2001). *Better Prevention, Better Services, Better Sexual Health: the National Strategy for Sexual Health and HIV*. London: Department of Health).

Vulnerable groups

Among those most at risk of suffering the effects of health inequalities are 'looked after' children, children from some minority ethnic groups, children in single parent households or households with low incomes, children experiencing abuse and/or domestic violence, homeless families, disabled children, travellers, refugees and asylum seekers.

The section below focuses on 'looked after' children, but children can also be at risk in their own homes from abuse, neglect and domestic violence and the impact of parental health problems, including mental ill-health or substance misuse.

'Looked after' children

A good deal of political and press interest in different family types focuses on the relationship between family formation and particular outcomes. The health and social outcomes for the children of lone parents, divorced parents, or gay and lesbian parents is extensively probed. There is a less substantial research literature on the impact of parenting in a different kind of family type – young people brought up in state care. We do, however, have data

showing that 'looked after' children and young people are more likely to have poor health, including poor mental health (Polnay and Ward, 2000; Richardson and Joughin, 2000) and poor health prospects. This is not, of course, a simple cause and effect relationship but is mediated by other factors including pre-care experiences. It is an area where we need to know more about what can be done to bring about improvement.

Children 'looked after' away from home often have extensive unmet health needs (Skuse and Ward, 1999). Of their sample of 249 children 'looked after' from a representative sample from six local authorities, Skuse and Ward found that 54% had unmet physical health needs, and a high percentage of children had emotional and behavioural disturbances. Children in residential care were significantly less likely to receive immunisations than those in foster homes. For almost two thirds of the children, there were incomplete records on when they last saw a dentist.

As Skuse and Ward point out, many of these children enter the care system with pre-existing risks – factors within their home circumstances may mean that they have missed out on health care in the past. They suggest that children 'looked after' may well need compensatory health care, so that once they become 'looked after', immunisations that had previously been overlooked can be given, dental caries treated and health education attended to. Skuse and Ward also suggest that the main reason why children 'looked after' away from home often have difficulty in accessing adequate health care is likely to be related to the frequency with which they move placements.

In their own study, only 44% of the children had stayed in the same

placement throughout the first year of their care episode, 26% had two placements and 28% three or more. Fifteen children (6%) had had five or more placements in this period. The most common age group in their sample was admitted under the age of one, and these had the second highest mean number of placements (Skuse and Ward, 1999:9).

Looking at children and young people brought up in state care, Mike Stein's overview (Stein 1997; 2004) reports that:

- Young people leave care to live independently at a much earlier age than other young people. Whereas the trend for young people in the general population is for delayed household formation, care leavers make an accelerated transition (Biehal et al, 1995).
- The educational qualifications and subsequent occupations of those who experienced care as children are much poorer than for those brought up in other kinds of family (Cheung and Heath, 1994).
- Young women in, and leaving, care have babies much earlier than other women. The study by Biehal and her colleagues showed a half of the sample coping with early motherhood by ages 16-19, whereas in the wider population, only 5% of 16-19 year olds had children.

In a study carried out in Wales (Payne and Butler, 1998), all 593 children 'looked after' by a single local authority on one day were looked at in relation to health care assessment. The authors found that 'looked after' children receive poor health supervision, even though it is required by regulation. In relation to immunisation,

'looked after' children were significantly less likely to be protected from infectious diseases than other 2-5s in the community. It was difficult to tell quite how much less likely they were to be protected because records were incomplete.

'Looked after' young people are also more vulnerable to mental health problems. In a study in Oxfordshire, McCann and colleagues (1996) found that 57% of young people living in foster care and 96% of those in residential care, had some form of psychiatric disorder. More recently, two national surveys of the mental health of young people in England (Melzer et al, 2000; 2003) obtained information on the mental health of young people living in private households and those 'looked after'. Comparisons between these two groups show that 'looked after' young people aged 11-15 years were four to five times more likely to have a mental disorder compared to the private household sample. The survey also established a close association between mental disorders and physical complaints along with an increased likelihood of smoking, drinking and drug use.

Young offenders

Young offenders are three times more likely to have a mental health problem than other young people. Many suffer from psychiatric disorders, anxiety and depression (Hagell, 2002). A study by Hammersley et al (2003) found that a quarter of young people supervised by Youth Offending Teams admit to having a mental health problem, a quarter to having self-harmed and almost a half to being depressed. Two out of five young men and two thirds of young women aged 16-20 who are sentenced in court have some mental health symptoms, compared to one in ten of the general population in this age group (Lader et al, 2002).

Young offenders may also have unmet physical health needs. The study by Hammersley et al (2003) found that a quarter of Youth Offending Team clients had never been to their GP. As Hammersley and his colleagues themselves point out extensive service use can be an indicator of psychosocial problems, whilst evidence of lack of service use can provide information about unmet needs.

There is some evidence to suggest that despite being at greater risk of health problems, particularly mental health difficulties, young offenders are not getting the health services they need. A report on youth justice by the Audit Commission (2004) points out that Youth Justice Board targets for mental health assessments for young offenders are not yet being met in most areas and that there are frequently conflicting priorities between Youth Offending Teams and Primary Care Trusts which militate against young people getting the health services they require. A study published in *The Lancet* found that young male offenders in local authority secure units do not get the mental health services they need, and that detention centres may lead to, or exacerbate health problems (Harrington, 2002). The Audit Commission report (2004) also points out that the provision of mental health care for young people in prisons is particularly poor. According to Youth Justice Board estimates, there are up to 300 young people in secure establishments requiring transfer to specialist mental health facilities at any one time, yet there are only around 30 secure NHS beds for young people with mental health problems (2004: 88).

Drug and alcohol use is also more common among young offenders who are around 10 times more likely to have a serious substance misuse problem than

non offenders (2004: 89). Appropriate specialist support to address these problems is widely reported to be inadequate.

Young offenders frequently have unmet educational needs and are more likely to have been brought up in poverty and/or the care system. A study carried out for the Youth Justice Board by Harrington et al (2005) found that almost a quarter of young offenders had learning difficulties, frequently had a history of social care placements, family breakdowns and school exclusions. The same study found that the provision of mental health services was patchy and variable and that needs often went unrecognised by those working with young people. More systematic mental health screening was a key recommendation.

Disabled children and young people

Families with disabled children have only 78% of the resources of all families with children (NCH, 1999). They are doubly disadvantaged because it costs three times more to raise a disabled child than a non-disabled child (Dobson and Middleton, 1999). Research has shown that overall, families from minority ethnic groups caring for a severely disabled child are even more disadvantaged than white families in similar situations, though families' experiences, needs and circumstances varied across ethnic groups (Chamba et al, 1999).

As Beresford (2002) points out, social exclusion permeates the lives of disabled children with consequences which are long-term and hard to reverse, and the experiences of social exclusion tend to increase as children grow older. Recent studies suggest that disabled children do not view themselves as intrinsically different to other children, but their treatment by others and their experiences of a disabling environment

promote a sense of difference. Disabled children most value services which support or promote 'ordinary', everyday activities and experiences.

There are several factors contributing to the social exclusion of disabled children and young people. These include transport, social and leisure needs, housing issues and involvement in decision-making. Accessible transport systems are fundamental to social inclusion.

Survey data show that disabled children and young people are significantly less likely to participate in sport and leisure activities, particularly out of school (Finch et al, 2001). Disabled children spend far more time in the home than non-disabled children, yet, for many children, the physical and social environment within the home is highly restrictive. The evidence emerging from practice, particularly from inclusive play and leisure projects, suggests that social inclusion can be achieved.

Refugee and asylum seeking (RAS) children and young people

The UK has, for many years, become home to refugees and the majority of refugees live in London. Figures from local education authority (LEA) data and language surveys suggest that almost one child in 19 in London is a refugee, and for a range of reasons, this is likely to be an underestimate. Reports from practitioners, researchers and young people suggests that provision needs to be urgently improved in a number of areas – for example, housing, education and training – if they are to have a fair chance of leading full and independent lives.

Poverty

Recent research commissioned by the GLA on the health of asylum seekers in temporary accommodation found that,

of asylum seeker respondents who had children, one in five could not afford books or toys for their children, a warm waterproof coat or fresh fruit and vegetables. The withdrawal in 2002 of the concession allowing asylum seekers to work after six months if waiting for a decision has undoubtedly increased levels of poverty.

Unemployment

Refugees are highly under-represented in the labour market. The situation of most young refugees and asylum seekers who are employed (illegally in the case of the latter) is that they work long hours, for little money, in a restricted number of occupations.

Housing

Research commissioned by the GLA in 2003 found that two fifths of asylum seeker households were living in overcrowded conditions (Mayor of London, 2004). The research highlighted serious safety concerns particularly for households with young children, for example:

- 60% of respondents had not been told what to do in case of fire or emergency
- Half of the respondents with children said that they had nowhere safe for their children to play indoors, and a third said they had nowhere safe outdoors
- About a third said that they did not think their accommodation had smoke detectors.

Concerns about fire safety were also raised, including gas leaks, electrical faults, faulty fire extinguishers and inadequate means of escape. Respondents described a range of serious accidents, fires and health

problems relating to their accommodation. The use of bed and breakfast and hostel type temporary accommodation raises child protection concerns as children often share facilities with other adults who are not their carers.

Education

Schools can play a crucial role in helping RAS children and their families to rebuild their lives and settle into their local communities. As Ofsted has noted, many refugee children do well at school because they are determined to succeed and have parental support. There is evidence to suggest, however, that Somali, Turkish Kurdish boys and Eastern European Roma are underachieving (Ofsted, 2003).

A recent GLA report revealed that around 10 per cent of RAS children are without a school place, rising to 14.2 per cent in inner London, compared to 5.6 per cent for England as a whole. London has high rates of mobility at secondary as well as primary school level. This poses particular challenges to schools and may make demands on staff, systems, resources, and on the more stable community of pupils. Research has pointed to a gap in attainment between the mobile and stable school populations.

Most child asylum seekers are highly motivated educationally and regard school as a sanctuary, but may become so depressed about the uncertainty surrounding their status that they do not see the point of going to school. Removals from school or while children are in transit to and from school are becoming more common (Vevers, 2004).

Health

While most refugees arrive in London in satisfactory health, some have distinctive

health needs (European Refugee Fund, 2004). Available evidence suggests that asylum seekers and refugees generally are in poorer health than the UK population as a whole, both physically and mentally. The experience of being a refugee, which may include exposure to violence and persecution, fleeing traumatic events, living as a marginalised exile and being separated from family can leave refugee children with health problems.

In a survey of 140 asylum seekers in one London borough, it was reported that 95 per cent had been refused GP registration at least once in the preceding 12 months. PCT officers further noted that poor access to GP services was reflected in high use of hospitals' A & E facilities by asylum seekers in London.

Organisations working with refugees and asylum seekers identified difficulties in accessing language support as a particular problem in accessing primary care in London.

Problematic drug use

A recent report by the GLA detailed how the lives of young refugees and asylum seekers in the UK are likely to be affected by particular circumstances which have been identified as risk factors for the development of problematic drug use (Mayor of London, 2004). For instance, young refugees and asylum seekers, especially unaccompanied minors, are frequently affected by social and economic exclusion which have been shown to be risk factors for problematic drug use.

Young people with a strong desire to learn and who have positive experiences of education are less likely to develop drug-related problems. However, some young refugees and asylum seekers face barriers to accessing or achieving in education. Therefore the role that

education can play in protecting these young people from drug-related problems is diminished.

The link between mental health problems and drug use is well documented and many young refugees and asylum seekers report depression, loneliness, and isolation. Homelessness and problematic drug use are also closely linked, and of particular concern is that some young refugees and asylum seekers have been, or risk becoming, homeless in the UK.

Children and young people's views on health and health services

There have been a large number of consultations on children's views on health and health services and social care (for example, Morgan, R (2005) *Younger Children's Views on Every Child Matters* – see references). Researchers are getting better at accessing children's views, but there is some scepticism about the extent to which these views feed in to policy and practice.

We therefore include in this section some of the views expressed by children and young people, in response to the consultation on the Mayor's draft *Children and Young People's Strategy*. The children at Northview Primary School who sent in their thoughts on making London a child-friendly city illustrate that children understand the importance of addressing the determinants of health and reducing inequalities. For example:

"I think it would be good if we have nature reserves because children would be learning about nature and having a good time."

"We think that smoking should be banned as it can cause lung cancer and can also tempt children to smoke when they're older."

"We could make more places for children like funfairs, more children's shops, cleaner swimming pools, football pitches and tennis courts."

"No more poor."

"More traffic lights, street police, street lights..."

"More car free streets so children can play sport on the street."

"Crime has to stop."

Children & young people's priorities

The priorities children and young people themselves identify vary in the same way as they do for adults. When asked specifically about their health priorities, most people (adults and children alike) will tend to focus on health care concerns (views on hospitals or what they think about their GP) or on the commonly understood lifestyle factors such as diet, smoking, exercise and sexual health.

Yet there are some important public health priorities which are consistently identified by children and young people in a range of community surveys and consultations. Probably the most important of these is access to play and leisure activities. The consultation involving 3,000 children and young people as part of the *Every Child Matters* process was no exception. Asked about the kinds of services they would like to see provided in their school (apart from education), sports activities and social events were the most popular.

In addition to structured activities such as after school and youth club

facilities, successive consultations have shown the importance to children of being able to play out safely and freely, whilst a number of recent studies have highlighted the restrictions placed on children's freedom due to fear of traffic and 'stranger danger' (for example, Demos/Green Alliance, 2004). A study carried out by Barnardo's & Transport 2000 (2004) similarly found that many children interviewed were fearful of walking and cycling in their neighbourhoods because of speeding cars.

There are obvious links between access to play and sports activities and health concerns such as child obesity. These are being recognised in government policy both through the inclusion of 'enjoyment' as well as 'achievement' in the ECM outcomes framework and in the emphasis on places to go and things to do for young people in the recent *Youth Green Paper*. However, we still have some way to go before children and young people's need for better access to public space is fully recognised and acted upon.

There have now been many consultations with children about health in general, about their own health and health care, and the health and health care of their families. Many familiar problems (food, cleanliness, noise, respect, time, friends, privacy and confidentiality) arise time after time.

In one London consultation (Liabo et al, 2002), children and young people appreciated the fact that the vast majority of health care is not provided by the health services but by their families. In that sense, children and parents are providers as well as users of health care.

*And how is it like when the doctor is examining teddy?
He feels like he's at home
Why is that?
'Cause sometimes when he's at home his mum might be his doctor and the doctor help him to get better.*

Girl in group of 6-7 year olds

One group of young people felt that health care facilities could be cheerier:

*Young man 1: You see white innit?
Young man 2: Exactly and the only posters they have up say you could die if you don't take this – and that's supposed to lift your spirits!
Young man 1: You just see white.
It feels like you're dead already man!*

Group of 14 and 15 year old young men

According to a group of learning disabled children and their teacher, not only were some of them under-consulted (while other groups were sometimes over-consulted), there were gaps in age appropriate, and sensitive services. It was clear from their accounts that a degree of sensitivity is required on the part of health professionals with this particular group. Most of the young people described how visiting the doctor made them feel "sad", "embarrassed" or "scared".

Because I had to lift my top.

In this study, a group with some of the highest expectations (and lowest opinions) of the health services were young people at risk of poorest health outcomes in the longer term – 'looked after' children, children in contact with the law, children from asylum seeking

families and so on. Lack of access to interpreting and translation, lack of continuity of care for some 'looked after' children, including unaccompanied asylum seekers and a lack of mutual respect between some of the more challenging young people and health care workers all presaged poor health care both now and in the future for precisely those groups at greatest risk.

*They don't talk to you. They do what they got to do and scruff you out the way...
They think, especially kids like us, they think we're faking it. We're lying: 'Just shut up and get on with it!'*

What do health inequalities mean for children?

Children and young people are not simply objects of concern, they are active citizens with views and rights. In order to provide services that will be effective, we need to understand children's own experiences and evaluations of services and resources. Abstract health issues are not, on the whole, ones which children themselves raise. But there is no doubt that they are aware of the links between health, wealth and well-being. A study carried out by Newman (2000) illuminates children's concerns with their present and future circumstances by asking a large sample of junior school children: "If you had one wish come true, what would it be?"

Children tend to have an instinctive understanding of injustice and inequality – "That's not fair!". On the whole, they appear to believe in equal shares. Responses to Newman's question were infused with generosity and altruism:

'If I had a wish I would wish that my house was not being repossessed.' (Girl, 10)

'I wish I would not suffer from asthma so my mother doesn't have to do so much dusting. I wish my dad could have more time off work' (Boy, 10)

'That my family could be safe all their lives in a safe street' (Boy, 11)

'I wish that I could help the poor people who haven't got no food, water or nothing.' (Girl, 8)

'I would wish for a big house for all the homeless and money for the homeless and some clothes and shoes because it is nasty for people to be on streets.' (Girl, 11)

Children's health in London now



In this section...

- Patterns of health and well-being among children and young people across London are outlined
- These patterns are set in the context of the "Be Healthy" outcomes framework of *Every Child Matters*

Introduction

Keeping children and young people well and narrowing inequalities gaps are important parts of what happens right across a whole range of sectors including education, social care, housing and transport in London. This section provides an overview of some of the factors important in assessing the state of the health of children and young people in London now. In exploring these, we relate health and ill-health data to the 'Be Healthy' indicators set out in *Every Child Matters*. These indicators relate to physical, mental and sexual health, health-related factors and children's lifestyles.

The Mayor's *State of London's Children* report (Hood, 2004) presents a summary of some of the most comprehensive data on children in London. The report indicates that:

- The pattern of childhood mortality (deaths of children aged 1-19) is similar in London to that nationally, though fewer die from road traffic accidents
- Rates of childhood immunisation are low in London compared with other cities
- The general health state of London's children is similar to children nationally, but healthier when measured by criteria of acute sickness
- Children in inner London are less likely to have good general health reports than children in outer London
- Young Londoners from black, mixed and Asian ethnic groups have marginally poorer general health reports than those from white and Chinese groups
- The prevalence of asthma is increasing, with evidence of childhood respiratory problems linked to living in a polluted area
- A pattern of restriction on children's independent mobility is commonly linked, along with dietary factors, to rises in childhood obesity (rates are particularly high in inner east London)
- Teenage pregnancy rates are higher in London than elsewhere and do not show a reducing trend, as nationally, though there are wide borough variations
- London has relatively large numbers of children affected by HIV within families
- Rates of mental ill-health amongst young people are increasing nationally, with research indicating even higher rates in inner London, particularly for boys aged 11-15.

This report takes a closer look at health-related inequalities among children and young people through the addition of borough-level, ward-level and other data.

Every Child Matters – be healthy targets and indicators

In this section, we draw on outcomes from *Every Child Matters (ECM)*, alongside indicators currently high on the national agenda (such as obesity) or important in London such as respiratory illness and teenage sexual health.

Table 2 'Be Healthy' targets and indicators from the ECM Outcomes Framework

AIMS	Physically healthy	Mentally and emotionally healthy	Sexually healthy	Healthy lifestyles	Choose not to take illegal drugs
TARGETS AND INDICATORS	Infant mortality rate (DH)	Death rate from suicide and undetermined injury (DH)	U18 conception rate (DfES/DH)	% Children who are regular smokers (DH)	Harm caused by illegal drugs (HO)
	% Obese U11 (DfES/DH/DM CS)	Improvement in access to CAMHS (DH)	Diagnostic rate of new episodes of STIs among U16 & 16-19yo (DH)	% Children consuming 5 portions of fruit and veg a day (DH)	has 3 components including reduce use of Class A drugs by under 25s (HO/DfES)

Physical health

Given that mortality (death) and morbidity (illness) are the key indicators here, we start with these.

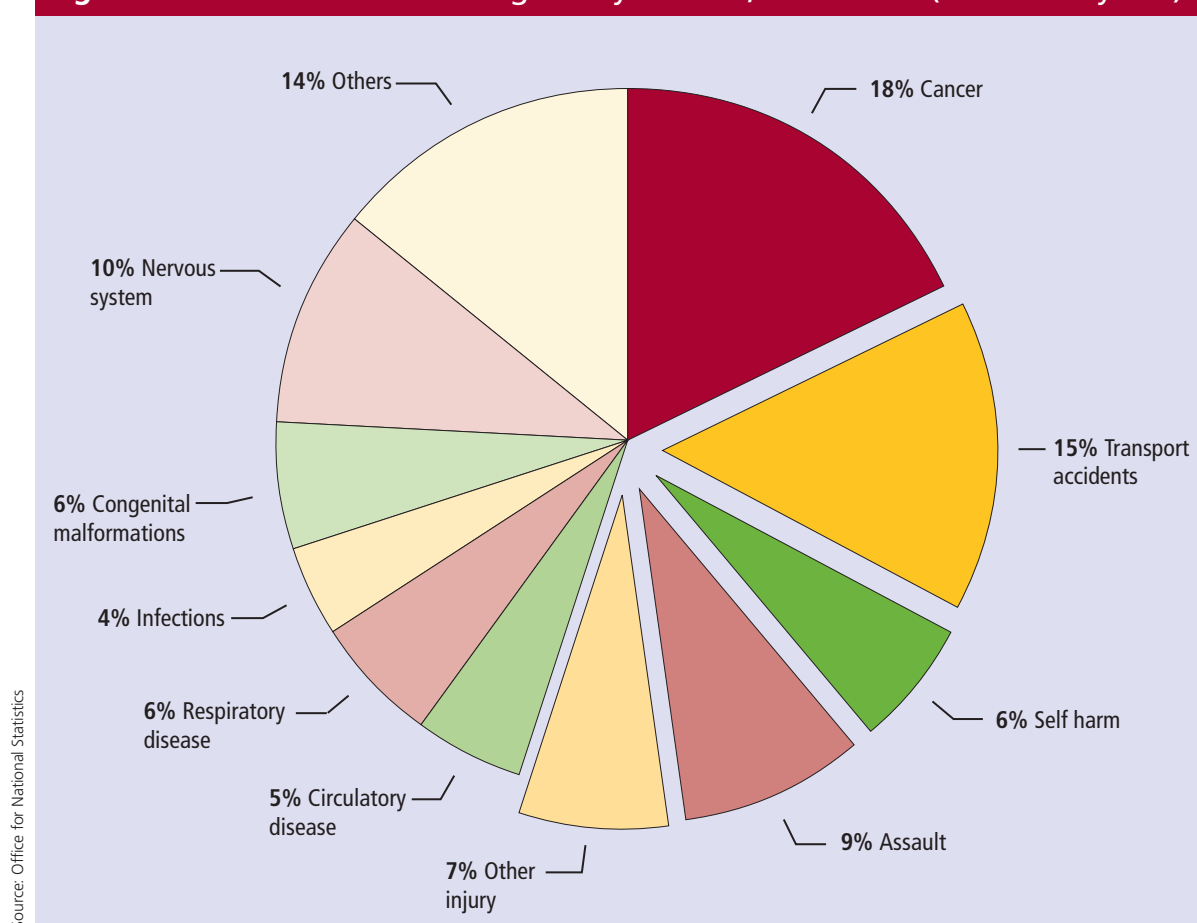
Mortality (death)

In societies with low death rates in childhood, there is a question about how useful mortality is as a marker for health and well-being. In our view, it remains a key marker, particularly since, as we describe below, many deaths are avoidable.

Death in childhood in London is not a common event, but every child's death is a tragedy. In London between 2001-03 there were 1,047 deaths of children aged 1-19 years. The main cause of death among children who were sick was cancer, equivalent to 18% of deaths. Diseases of the nervous system accounted for 10% of deaths, respiratory diseases 6% and infections 4% (Figure 2).

However, the majority of deaths were not the result of illness, but of injury. Road traffic injuries, self-harm, assault and other injuries resulted in a total of 37% (383) of all deaths in 1-19 year olds. Of these, 156 (15%) were transport accidents. They are not, however, entirely 'accidental' as the patterns of deaths by social class indicate. A poor child or young person is much more likely to be killed in a road traffic accident or a house fire than a 'better off' child. Self-harm resulted in 6% of deaths and assault 9%. Seven per cent of deaths related to other injuries.

At the national level, a child from the poorest background is 16 times more likely to die in a house fire as well as being five times more likely to die as a pedestrian than a child from a 'better off' household (Towner et al, 2005 http://www.hda.nhs.uk/documents/injuries_in_children_inequalities.pdf) This is an area where wealth and health

Figure 2 Cause of death among 1-19 year olds, 2001-2003 (combined years)

can be seen in operation in a very stark way.

Morbidity (illness) indicators

Most illness, serious or less serious, is dealt with in the home by parents, usually mothers. Hospital admission usually, though not invariably, denotes more rather than less serious problems. Most children who become ill, including those who become seriously ill, recover.

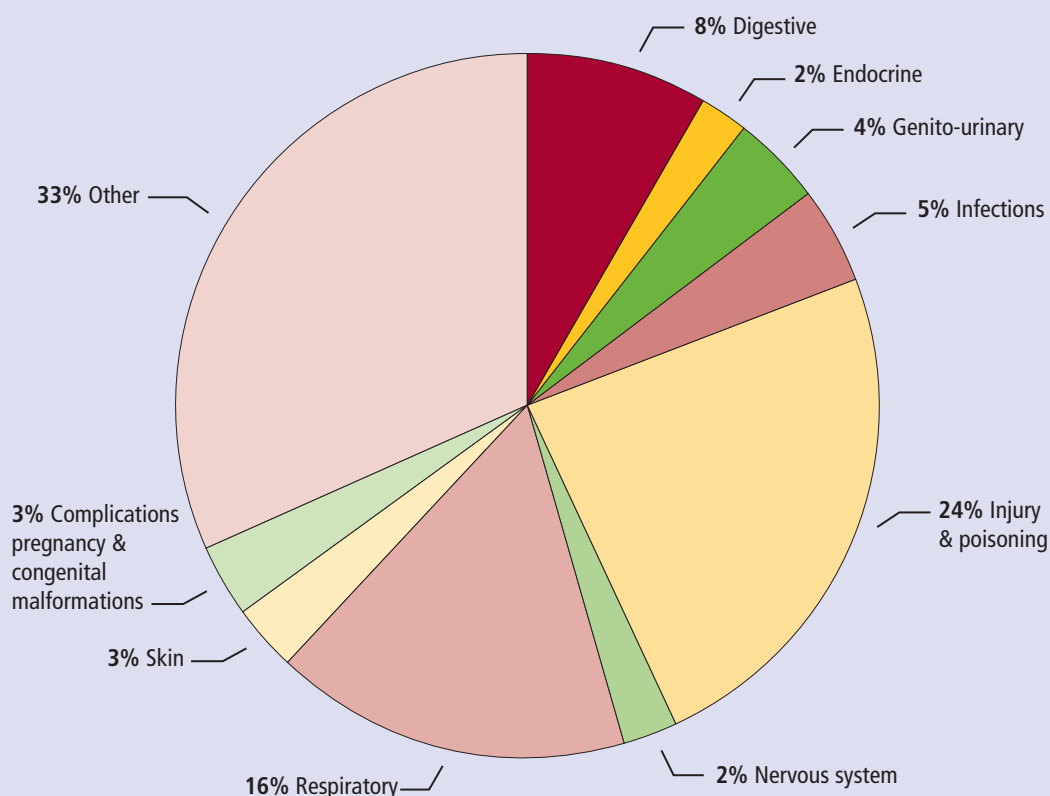
Emergency admissions to hospital

The rate of emergency hospital admissions is highest among children under one year of age. Illness in babies can be sudden and severe (and recovery often fast). Emergency admission rates for under one year olds are highest in Hackney, Islington and Tower Hamlets, and lowest in Havering, Hillingdon and Kensington

and Chelsea. Emergency admission rates for 1-19 year olds are highest in Hackney and lowest in Kensington and Chelsea. Emergency admission to hospital can depend on a number of factors in addition to the severity of illness. These can include proximity of hospital, levels of anxiety of medical staff or parents and in some cases, home circumstances.

The kinds of problems which cause 1-19 year olds to be admitted to hospital as an emergency are shown in Figure 3. Of those where we know the cause, injury and respiratory problems are the most common causes of admission.

In a report with a special focus on inequalities in children, it is particularly important to see whether deprivation plays a part in hospital admission. Are children in deprived boroughs more or less likely to be admitted to hospital? Map 1 suggests that in the inner

Figure 3 Hospital emergency admission by cause among 1-19 year olds, 2003/04

Source: Hospital Episode Statistics

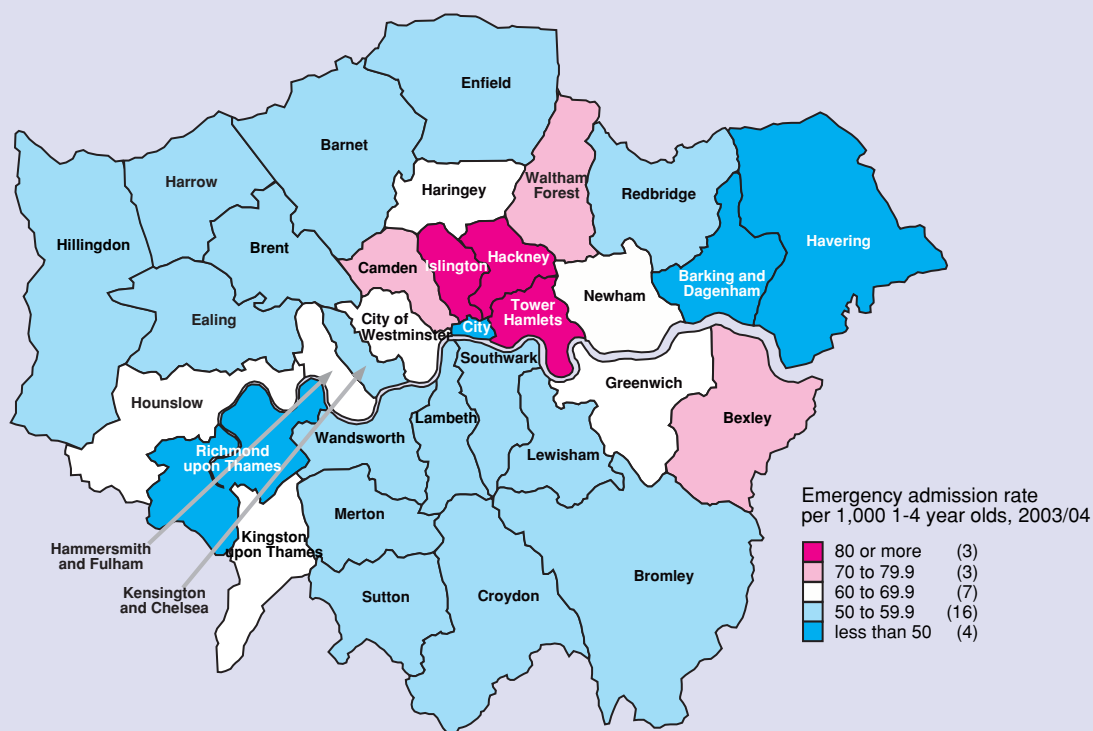
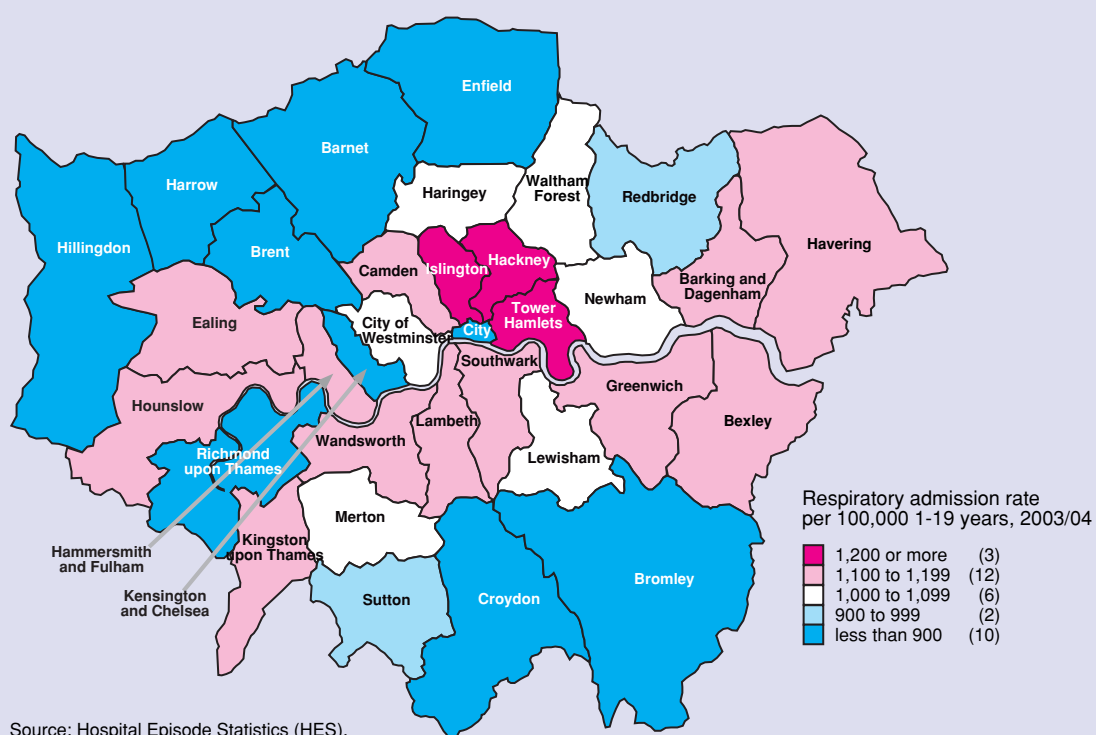
London boroughs of Hackney, Islington and Tower Hamlets, 1-4 year olds are more likely to be admitted to hospital in an emergency than children in other boroughs. In outer London, 1-4 year olds from Havering and Richmond are least at risk of hospital admission.

To understand these patterns better, we would need to know more about the number of children at risk of admission (i.e. how many children become ill with similar complaints), and how many of them come to the hospital's attention.

Respiratory illness is a particular cause for concern in London, and many emergency hospital admissions are related to asthma. Map 2 shows hospital admission rates for respiratory disease by borough and indicates that there are variations across boroughs. Whether this is related to differences in prevalence of

respiratory problems or difference in the management of those problems by professionals, parents and young people is difficult to determine.

There may be many contributory factors related to the development of respiratory illness such as asthma which are a result of changing lifestyles. We are more likely to have centrally heated homes with fitted carpets and little ventilation – ideal conditions for the house-dust mite, a very common asthma trigger that lives in soft furnishings. Our diets now include fewer fresh foods although evidence suggests that eating plenty of fruit and vegetables can help to reduce asthma symptoms. Other theories include less exposure of young children to infections than previously, which might explain why younger siblings and children who attend day nurseries seem to have a lower risk of developing asthma.

Map 1 Hospital Emergency Admission Rates for 1-4 year olds, 2003-04**Map 2 Hospital Admission Rates for respiratory disease per 100,000 for 1-19 year olds, 2003-04**

Asthma develops more commonly in children whose parents smoke (Royal College of Physicians, *Smoking and the Young*, London 1992). Although both tobacco smoke pollution and other air pollution can cause or exacerbate symptoms in people who already have asthma, there is no evidence that air pollution other than tobacco smoke actually causes asthma (LHO overview, see http://www.lho.org.uk/HIL/Disease_Groups/RespiratoryDisease.aspx). Seasonal variations in admissions appear to be largely due to respiratory problems (Damiani and Dixon, 2001) with six clinical conditions implicated:

- chronic obstructive airway disease (COAD)
- pneumonia
- other acute respiratory tract inflammations
- asthma
- bronchiolitis
- upper respiratory tract infections.

While young children occupy a high number of bed days, the average length of stay is generally very low – 2-3 days. For more information see LHO website at http://www.lho.org.uk/HIL/Disease_Groups/RespiratoryDisease.aspx

Obesity

A particular public health concern at present nationally and internationally is obesity. Being overweight in childhood presages poor health outcomes in the longer term. Being overweight and obese are more common in more deprived areas and there has been a steady upward trend in the prevalence of obesity. Unfortunately, there are currently no overall data on obesity at a borough level in London, although there are important studies which collect data in some boroughs, such as the RELACHS study described overleaf.

A London boost to the *Health Survey for England* is to be commissioned in order to obtain these data, as there is an urgent requirement for more data on obesity at borough level. While there is a commitment in the government White Paper on public health, *Choosing Health* to measuring obesity, there are concerns that focusing on individuals rather than on a whole school/community approach to tackling the problem may be unhelpful.

A note on definitions

Measuring obesity among children uses different methodology from measuring obesity among adults. Different growth patterns among boys and girls at each age mean that a universal categorisation cannot be used. Each sex and age group therefore needs its own level of classification for obesity (Jotangia et al, 2005). There is currently a lack of consensus on the classification of the UK National Body Mass Index (BMI) in children. The UK National BMI percentile classification has been the most commonly used measure in the past for reporting on obesity, for example, the *Chief Medical Officer's 2002 Annual Report* and most recently in the 2005 data from Jotangia et al. This uses the 85th and 95th percentiles of the 1990 UK (UK 90) data cut-off points for overweight and obesity respectively.

An alternative method is the International Obesity Task Force (IOTF) international classification using data collected from six countries using 190,000 subjects in total aged from 0-25 (UK, Brazil, Hong Kong, The Netherlands, Singapore and the United States). This has the advantage of enabling international comparisons and the IOTF cut-off points for overweight and obesity.

Percentage of obesity (in under-11 year olds)

The most recent national data (Jotangia et al, 2005) indicate that compared with the overall level of childhood obesity, only London and the North East Region had significantly different rates of obesity to the average (Table 3). The report presents key information for 1995 to 2003 on obesity among children aged under 11 living in England. Results and analysis are based on data from the *Health Survey for England* (HSE).

The report uses the data for 2001 and 2002 combined when analysing the relationships between social demographic factors and obesity. It uses the UK National Body Mass Index (BMI) percentile classification to describe childhood overweight and obesity among children aged 2-10. Prevalence of obesity in London (18%) was three percentage points higher than the national average (15%) using UK 90 definitions (Jotangia et al, 2005).

The authors also report that between 1995 and 2003, the prevalence of obesity

among children aged 2-10 rose from 10% to 14% and the percentage of children aged 2-10 who were overweight (including those who were obese) rose from 23% in 1995 to 28% in 2003, also using the UK 90 definitions.

Ethnicity and childhood obesity

Few studies have examined ethnicity and overweight in UK children or adolescents. In 1999, the HSE found that 23% of English children and young adults aged 2-20 years were overweight or obese (24% of females, 22% of males), and 6% obese using IOTF cut-offs. African-Caribbean and Pakistani girls were more likely to be overweight (Saxena et al, 2004).

In London, data showing a relationship between ethnicity and weight in adolescents can be found in the RELACHS study (*Research in East London Adolescents Community Health Survey*) study, which is a longitudinal school based survey of adolescents. Cross-sectional (2001) data from this study indicated that a quarter of the respondents then aged 11-14 years in three deprived London boroughs (Hackney, Tower

Table 3 Obesity prevalence among children, by Government Office Region

Aged 2-10 with valid BMI								2001-2002	
BMI status	Government Office Region								
	North East	North West	Yorkshire & Humber	East Midlands	West Midlands	East England	London	South East	South West
	%	%	%	%	%	%	%	%	%
Obese	18.3	15.0	11.4	14.5	15.8	14.1	18.2	13.4	14.0
Bases (weighted)									
Aged 2-10	394	950	750	615	748	791	830	1077	683
Bases (unweighted)									
Aged 2-10	355	806	634	540	636	693	701	922	588

Hamlets and Newham) were overweight, and 7-10% obese using IOTF cut-offs. Two per cent were extremely obese.

Obesity and overweight were common across ethnic groups, although there were some ethnic group differences, with Indian boys at increased risk compared to white British males. Although there were significant differences in BMI between ethnic groups, high levels of overweight were seen in all ethnic groups. No associations between BMI and measures of socio-economic status were found (Taylor et al, 2005), but this may be explained by the high level of deprivation in the whole area surveyed, with every ward in the bottom quintile of the DETR deprivation index (Fitzpatrick and Jacobson, 2001).

Percentage of children consuming five portions of fruit and vegetables a day

In 2002, children and young people in London had the highest fruit and vegetable consumption of any English region (mean 3.1 daily portions aged 5-15 and 16-24 years), but this still falls short of the recommended five daily portions.

The proportion of young people eating five or more daily portions of fruit and vegetables was 19% of boys and 17% of girls aged 5-15, and 19% of males and 22% of females aged 16-24 years (Sproston & Primatesta, 2003 – Health Survey for England, 2002).

Mental and emotional health

A major national survey of the mental health of 5-15 year olds in the UK found that rates of mental disorder were higher in inner London than in other areas of

the UK, and particularly high for boys aged 11-15 years. Addressing emotional well-being for London children is clearly an important issue. While the medicalisation of distress can be unhelpful, we report here some of what is happening at the most serious end of the spectrum, before looking at the generalised lack of well-being that can be so corrosive for young people, and damage childhoods.

Mental health is more profoundly affected by socio-economic factors than many other dimensions of health (Carr-Hill et al, 1994).

Suicide

Over the last century, there has been a large increase nationally in the proportion of deaths among young people attributable to injury and suicide. This toll of suicides, particularly among young men, together with the increase in mental health problems in children and young people, demonstrates the urgent need to focus on improving social and emotional health.

There were 13 suicides during 2001-2003 in people aged under 15 years in London. Given the small numbers, further analysis of these deaths has not been undertaken. Suicide in young people is generally associated with older children and adolescents. Moving to the 15-19 year age group, there were 59 deaths from suicide and undetermined injury (41 males, 18 females) during 2001-03. This comprises 3% of the total in London. This rises to 142 (7.4% of the London total) in people aged 20-24 years.

Self-harm

Young people may deliberately harm themselves in a variety of ways including substance abuse, the use of alcohol, overdosing and cutting or burning themselves with cigarettes.

Table 4 Deaths from suicide and injury of undetermined intent in London residents aged 15-24 years

	Male	Female	Total	% Total suicide deaths in London	% Total suicide deaths in England
Under 15	–	–	13	–	–
15-19	41	18	59	3.1	3.2
20-24	109	33	142	7.4	6.6
All ages	1,379	537	1,916	100	100

Source: ONS mortality data analysed by LHO

As Figure 4 shows, there are quite large disparities between boroughs on hospital admissions rates for self-harm with Waltham Forest, Lewisham, Islington and Hillingdon showing particularly high rates, and Bexley and Sutton the lowest rates. However, these differences will be partly due to variations in the quality of hospital diagnoses coding between hospitals.

Mental health

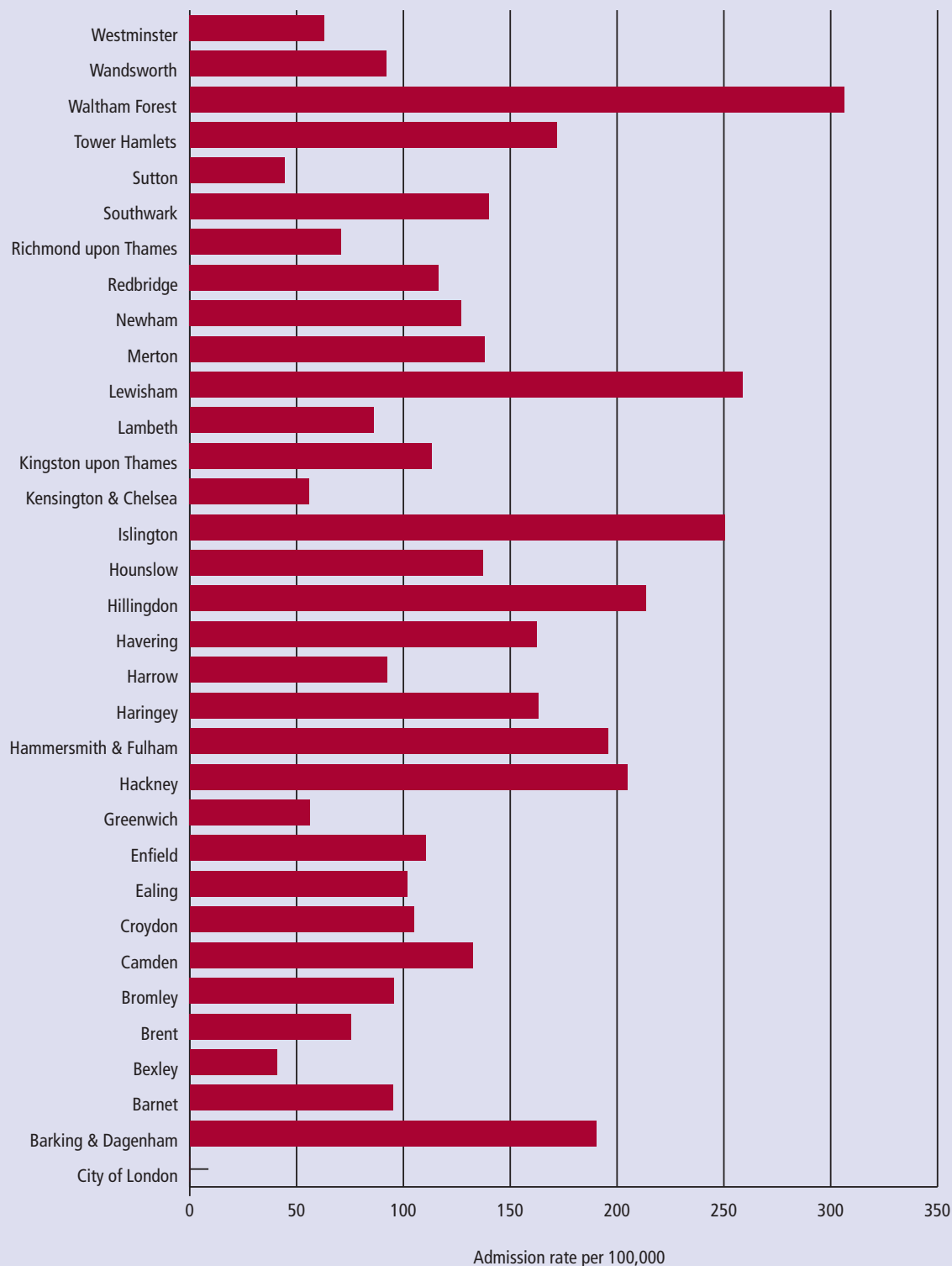
An Office of National Statistics (ONS) report in 2000 collected data on mental health problems among children and young people. They used the term mental disorder to refer to a clinically recognisable set of symptoms and behaviours associated in most cases with considerable distress and substantial interference with personal functions. The survey concentrated on the three common groups of disorder: emotional disorders such as anxiety, depression and obsessions; hyperactivity disorders involving inattention and over-activity; and conduct disorders characterised by awkward, troublesome, aggressive and anti-social behaviours (Meltzer et al, 2000).

The importance of collecting these kinds of data are that they allow decisions to be made about the provision of mental

health services for children, and give a picture of the burden on children and others of mental health problems. Table 5 shows that while children in London aged 5-10 have much the same level of mental health problems as children in the rest of the country, 11-15 year old boys in inner London in particular have much greater difficulties than boys of the same age elsewhere in England.

Data from the ONS survey on the mental health of 'looked after' children aged 5-17 years found that 45% of those interviewed (1,039) were assessed as having mental health problems and 37% had symptoms that warranted a clinical diagnosis. Those in care were five times more likely to have a mental disorder (42% compared with 8%), with particularly notable differences in conduct disorder.

The RELACHS study, referred to previously, reported rates of psychological distress in east London considerably higher than national rates. High levels of psychological distress measured by the *Strengths and Difficulties Questionnaire* were reported by 16% of boys and girls in year 7. In year 9, high levels of

Figure 4 Hospital admission rates for self-harm per 100,000 aged 10-19 year olds, by borough 2003/04

Source: Hospital Episode Statistics

psychological distress were reported by 12% of boys and 18% of girls. Boys had higher rates of psychological distress at 11-12 years than 13-14 years, while for girls the reverse was the case. Girls had more emotional disorders and boys more

conduct disorders in both age groups. Part of the explanation for higher rates in east London may be methodological but this is unlikely to explain these differences entirely (Institute of Community Health Sciences, 2003).

Table 5 Prevalence of Mental Disorders, by region, sex and age, 2000

	Inner London %	Outer London %	Other Met England %	Non Met England %	England %
Boys					
5-10 years	9.1	10.2	11.5	10.5	10.8
11-15 years	20.4	13.9	11.2	13.4	13.1
All boys	14.8	11.6	11.4	11.7	11.8
Girls					
5-10 years	6.1	8.2	6	5.5	5.9
11-15 years	8	5.8	11.1	9.3	9.6
All girls	6.9	7.1	9.3	7.2	7.5
All Children					
5-10 years	7.5	9.2	8.7	8	8.3
11-15 years	14.6	9.4	11.2	11.3	11.3
All	10.9	9.3	9.8	9.4	9.6

Source: Adapted from ONS Survey: the mental health of children and Adolescents in Great Britain, 2000,
(taken from State of London's Children Report, GLA, 2004)

Improvement in access to child and adolescent mental health services (CAMHS)

There are no comprehensive London data currently available, although a mapping exercise across London is currently taking place.

This will cover partnership working, strategy, commissioning, multi-agency provision of comprehensive CAMHS, workforce, specialist CAMHS infrastructure, and the appropriateness, accessibility and acceptability of interventions.

Sexual health

The areas of sexual health that this report covers – under-18 conception rate and sexually transmitted infections – are two which show marked inequalities and can affect the health of children and young people both now and in the future.

Under-18 conception rate

Conception and birth rates in the UK are the highest in Europe and second only to the United States in the developed world.

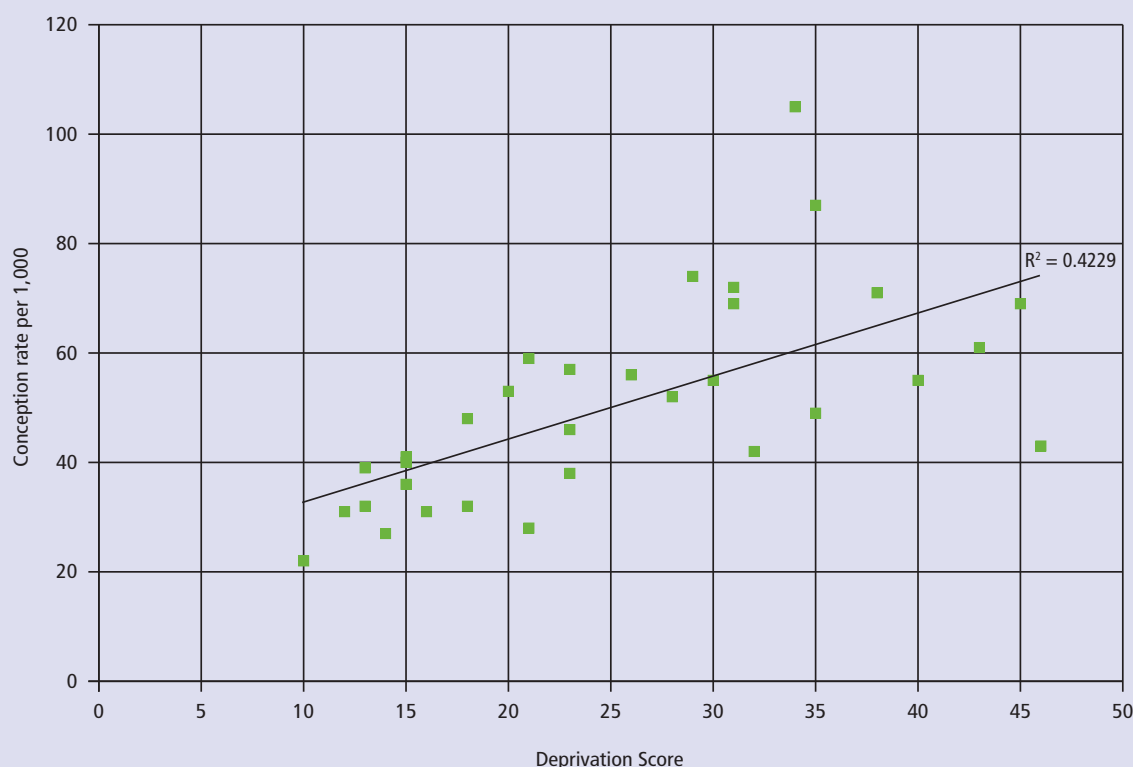
In 2003, London had an under-18 conception rate of 51 per 1,000 – 21% higher than the rate for England (42 per 1,000), and the second highest regional rate behind the North West (52 per 1,000). London boroughs have both the highest and lowest under-18 conception rates in England – over 100 per 1,000 in Lambeth, and less than 30 per 1,000 in Richmond and in Harrow.

For younger girls, London has the highest under-16 conception rates in England with 10 conceptions per 1,000 girls aged 13-15 years, compared to an England average of 8 per 1,000.

London's high rate is linked to particularly high rates in inner London, with marked differences in teenage conceptions between boroughs and

Figure 5 Under-18 conception rate and deprivation by London borough, 2003

Source: Office for National Statistics and Teenage Pregnancy Unit



wards. This is illustrated in Figure 5, which clearly demonstrates wide differences related to deprivation.

Sexually transmitted infections (STIs)

Section 2 describes the growing number of sexually transmitted infections. Here we describe the impact of some of these in London.

Figure 6 shows the trends in the number of chlamydia and gonorrhoea diagnoses among those aged 16-19, indicating, in particular, the very steep rise in chlamydia in the last decade among 16-19 year old girls.

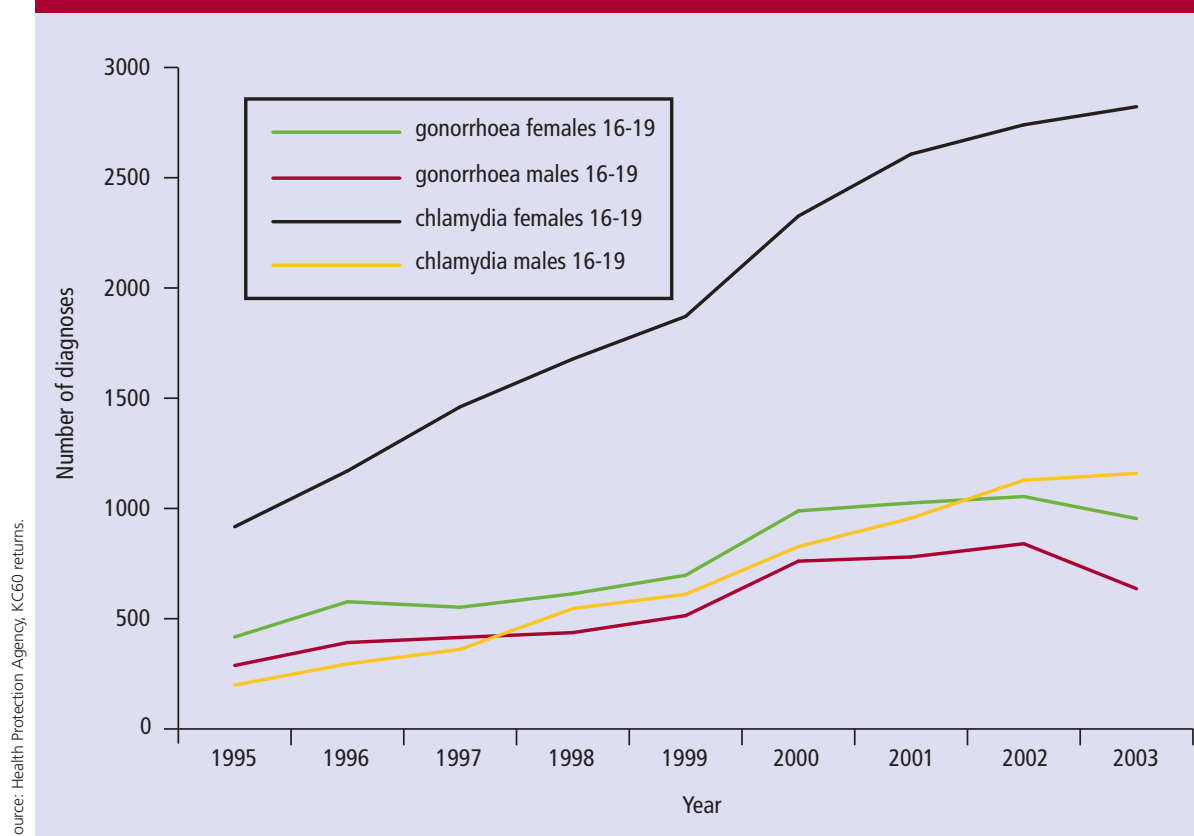
As Figure 6 also shows, levels of gonorrhoea are also a cause of concern for young people in London. While the diagnoses appear to be dropping from around mid 2002, they remain high compared with a decade ago. Diagnoses in boys and girls under 16 raise child protection as well as other health concerns.

New diagnoses of gonorrhoea also show a marked difference from the rest of England, with gonorrhoea at approximately double the England rates and particularly high levels amongst young women in north central London (Figure 7).

Sexual behaviour is a major factor determining the incidence of STIs. The second *National Survey of Sexual Attitudes and Lifestyles* shows that there have been notable changes in sexual behaviour since the first survey in 1990. These include:

- a greater number of lifetime partners
- lower median age at first intercourse
- a greater proportion of the sample with concurrent partnerships
- a greater proportion with two or more partners in the past year who did not use condoms consistently. However, there has also been an increase in the proportion who use condoms at first intercourse.

Figure 6 Number of Chlamydia and Gonorrhoea diagnoses in London among those under 16 and aged 16-19, 1995-2003



Contraceptive use

In terms of contraceptive use specifically, a study of teenage pregnancy in east London (Viner et al, 2005) found that:

- Young people who are having, or thinking about having, sex recognised the need to use contraception (although at times they might not do so). 83% of those who had had intercourse reported using one or more forms of contraception when they last had sex. Young women reported more unprotected sex than young men.
- No ethnic differences in types of contraceptive use were identified.
- Double protection (using a condom and the contraceptive pill) was used by only 10% of young people the last time they had sex.
- There were differences in the use of contraception both between ethnic groups, and within ethnicities commonly grouped together as 'Black'. While Black Caribbean young men were more likely to have had sex than White British young men, they appeared less likely to have unprotected sex than White British young men. In comparison to White British young men, Black British young men reported less unprotected sex, while Black African young men reported similar use of contraception to White British young men. This emphasises the importance of tailoring interventions to the needs of sub-groups and individuals rather than assuming that needs can be gauged from broad categorisations.
- Young people from 'non-White' ethnic groups were more likely to have unprotected sex if they had been in a relationship for six months or more, compared with relationships

of one month or less. This emphasises the need for interventions to address issues around continuing protection in long-term relationships.

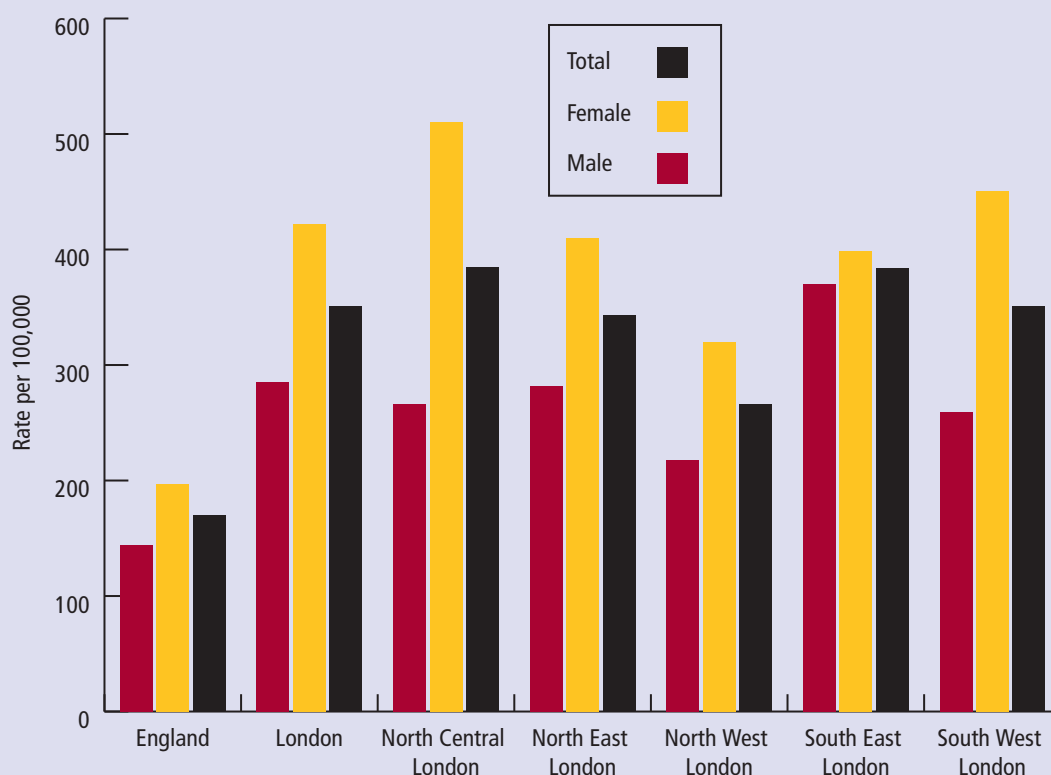
- Special needs groups such as those with learning difficulties appear to need better access to services.

Healthy lifestyles

Average alcohol consumption

Young Londoners appear to consume less alcohol than young people in other regions. Mean weekly units of alcohol consumed by young Londoners in 2002 was 18.4 for males and 10.3 for females. This compares with 30.9 units by young men in Yorkshire and Humber; and 18 units by young women in the North East, the highest regional rates. Young Londoners are also considerably more likely than a national sample to report that they never drink (70% of boys and 76% of girls, and 21% of young men, 24% of young women). However, nationally the prevalence of alcohol drinking amongst young people aged 11-15 years increased markedly from 1996 to 1998 and has since fluctuated. The average amounts drunk has also increased over the

Figure 7 Rates of new episodes of gonorrhoea (per 100,000) among 16-19 year olds, by London strategic health authority, 2004



Source: Source: Health Protection Agency, KC60 returns.

same period from 5.3 to 9.9 units (Department of Health, 2004).

There is some evidence that the levels of alcohol-related morbidity and mortality in London are greater than would be expected from the level of alcohol consumption, indicating that alcohol-related harm is not simply determined by the quantity individuals consume. In addition, children and young people may be adversely affected by parental alcohol problems and many children in London are growing up in households where at least one parent has an alcohol problem. More information about the impact of alcohol on individuals and communities in London can be found in the Mayor of London, *The London agenda for action on alcohol: Mayor of London's priorities to reduce alcohol-related harm in the capital*, November 2003
http://www.london.gov.uk/mayor/health/drugs_and_alcohol/index.jsp

Percentage of children who are regular smokers

One in ten children aged 11-15 years in London currently smoke. This compares to one in four adults. Nationally more secondary school girls than boys smoke (11% and 7% respectively). In general, smoking prevalence is higher in more deprived areas, but in London there are also marked ethnicity and gender differences. There is a tendency for London to show lower prevalence of smoking across all age groups than other regions (*Health Survey for England*, 2002).

Second-hand smoke

Children are also affected by second-hand smoking. Smoking during or after pregnancy causes one in two cot deaths (Sudden Infant Death Syndrome). Infants whose parents smoke have four times the risk of being admitted to hospital

with a respiratory infection before their first birthday. Parental smoking increases the risk of middle ear infections in childhood.

In general, smoking prevalence is higher in more deprived areas but in London there are also marked ethnicity and gender differences. Cigarette smoking is highest amongst Turkish (55-74%), Bangladeshi (44%) and Irish men (42%). Smoking rates are often, but not always, low among women from Black and minority ethnic groups: while only 1% of Bangladeshi women smoke, 45-59% of Turkish women and 39% of Irish women do so. However, a fifth of Bangladeshi women use chewing tobacco, which also carries serious, though fewer, health risks.

Choosing not to take illegal drugs

Harm caused by illegal drugs (including use of class A drugs by under 25 year olds)

In England the prevalence of drug taking amongst 11-15 year olds remained relatively stable between 1998 and 2003. Cannabis was the most likely drug to have been taken (13% of 11-15 year olds had taken cannabis) and 4% of young people had taken a class A drug, such as heroin and cocaine in the last year (*Survey of Drug use, smoking and drinking among young people in 2003*, Department of Health).

Because drug use is an illegal activity, it is not easy to obtain accurate information about the extent of its use. However, the annual *British Crime Surveys* provide some useful information on estimated use and show that rates of drug use in London remain consistently higher than other regions in England and Wales. The 2000 BCS reported that 31% of 16-29

year olds in London had taken an illegal drug in the previous year (Mayor of London, London: *The highs and the lows: A report from the Greater London Alcohol and Drug Alliance incorporating the findings from the London Drug Indicators Project*, February 2003)

Information collated and analysed by the Greater London Alcohol and Drug Alliance (GLADA) for the *London Crack Cocaine Strategy* highlighted the growth in use of crack cocaine and demonstrated that the scale of the crack cocaine problem in London is much larger than elsewhere in the country (Mayor of London, *The GLADA Crack Cocaine Strategy 2005-08*, December 2004.)

Although information about the impact of drug use on different communities is also limited, there is increasing evidence of a strong relationship between poverty, social exclusion and problematic drug use.



The ten high level indicators



In this section...

- The indicators for the *London Health Strategy* are examined, with an increased focus on children and young people

The indicators and their relevance to reducing health inequalities

The indicators for the London Health Strategy can be used to measure changes over time and monitor progress towards reducing health inequalities. These indicators are shown in Table 6 opposite with a brief summary of their relevance to health and health inequalities.

These indicators are designed to provide information on, and to monitor trends in, health and key determinants of health. Over time, they can be used to look at trends in health inequalities, which can help to identify areas for action. They are 'high level indicators' and are not designed to be used for monitoring the effects of a specific project or strategy. Many different factors affect each of the indicators and it is not possible to attribute a change in one of them to a specific activity.

The indicators are by definition limited and selective. For example, they do not capture the qualitative experiences of children and young people experiencing material disadvantage, some of which are reported in Section 2. Nor can they capture the compounding effects of multiple deprivation. For more detailed information about the indicators, including definitions and how indicators have been developed, see Appendix 2 of last years report at www.londonhealth.gov.uk/hinl2004.htm

The ten high level indicators:

- Provide a 'snapshot' of the current status of seven of the key determinants of health and three health outcome measures.
- Enable trends to be measured over time. Since many trends take some

years to emerge, and year-on-year trends can be misleading, these are not reported every year. No trends are available in this year's report as this is the first year of monitoring children's health inequalities.

- Enable comparisons to be made between different areas within and outside London and among different groups in the population.

Indicator ■ – Unemployment

Non-employment among households with dependent children is strongly associated with child poverty. Child poverty impacts on children's future chances of social inclusion: on their health, education and social and psychological development. Unemployment is thus a significant risk factor for poor physical and mental health and a major determinant of health inequalities. It is associated with morbidity, injuries, and premature mortality, especially through increased risk of coronary heart disease. It is also related to depression, anxiety, self-harm and suicide.

As this year's report focuses on children and young people, we describe here some of the data on both lack of employment or education among young people themselves and on being a child in a household where no adult is in employment (referred to as 'workless households').

Key findings

- The most recent Department for Work and Pensions (DWP) incomes data shows that 41% of all children in London, and over half of all children in inner London are living in poverty. Child poverty is strongly

Table 6 High level indicators

<i>London Health Strategy – high level indicators</i>	Relevance to health inequalities	Indicators relevant to children and young people selected for this year's report
1 Unemployment	Associated with morbidity, injuries, poisoning and premature mortality, especially coronary heart disease. Also related to depression, anxiety, self-harm and suicide.	Dependent children with no adults in employment in the household; young people not in full-time education or employment; types of workless household with dependent children
2 Unemployment among Black and Minority Ethnic (BME) population	As above	Children in workless households by ethnicity
3 Educational attainment: percentage of pupils achieving 5 GCSE grades, A*-C	Education reduces risk of unemployment and poverty which have a negative effect on health	In addition to GCSE grades used in previous reports, Key Stage 1, 2 and 3 performance; ethnicity and educational achievement
4 Proportion of homes judged unfit to live in	Can cause or contribute to ill health or injury and exacerbate existing conditions e.g. through damp, cold, poor design or bad lighting	Dependent children living in overcrowded housing by ethnic group and London borough; homeless families with children living in temporary accommodation
5 Burglary rate per 1,000 population	The factors that affect the local crime rate also seem to affect health. Crime can also affect health directly through feeling unsafe	Victims of crime, perpetrators; impact on future prospects and future health
6 Air quality indicators – NO₂ and PM₁₀	Polluted air can damage health. The young, the elderly and those with respiratory difficulties are particularly vulnerable	Air quality indicators – NO ₂ and PM ₁₀
7 Road traffic casualty rate per 1,000 population	Road traffic accidents are a major avoidable hazard to health, and there are large social class differences	Fatal and serious casualties by mode of travel; child road casualties in London boroughs
8 Life expectancy at birth	A good summary indicator of the health status of the population	Life expectancy at birth by borough for males and females
9 Infant mortality rate	The infant mortality rate is influenced by maternal health, social class and quality of care	Infant mortality, stillbirth rates, perinatal and neonatal mortality rates, and proportion of low birth weight babies by borough
10 Proportion of people with self-assessed good health	A good indicator of health status in adults	Dependent children with a limiting long-term illness; population aged 10-14 who view their health as good; 15-19 year olds who view their health as good; 10-19 year olds reporting their health as good by ethnicity

associated with non-employment among households with dependent children (DMAG briefing, 2005/22).

- Workless households with dependent children in London accounted for one in five of all such households in England (Census 2001). There are

significant differences between inner and outer London with the inner London figure far higher than for any region in England (DMAG briefing, 2003/21).

- Around 23% of dependent children in London live in households where there are no adults in employment compared with 17% nationally.
- Around 84% of people aged 18-24 are in employment or full-time education in London. This is just above average, although London has the lowest proportion of these in employment and the highest percentage in education.
- The proportion of young people not in full-time education or employment ranges from 7% to 33% in the London boroughs. The highest proportions are found in Newham, Southwark, Tower Hamlets, Enfield, Greenwich, Barking and Dagenham, and Islington, where at least 25% of young people are not in full-time education or employment.
- The outer London boroughs tend to have the lowest rates of young people not in full-time education or employment. Harrow, Sutton, Hillingdon, Havering, Kingston, Richmond, Merton and Hounslow all have rates of less than 15%.

Young people and unemployment

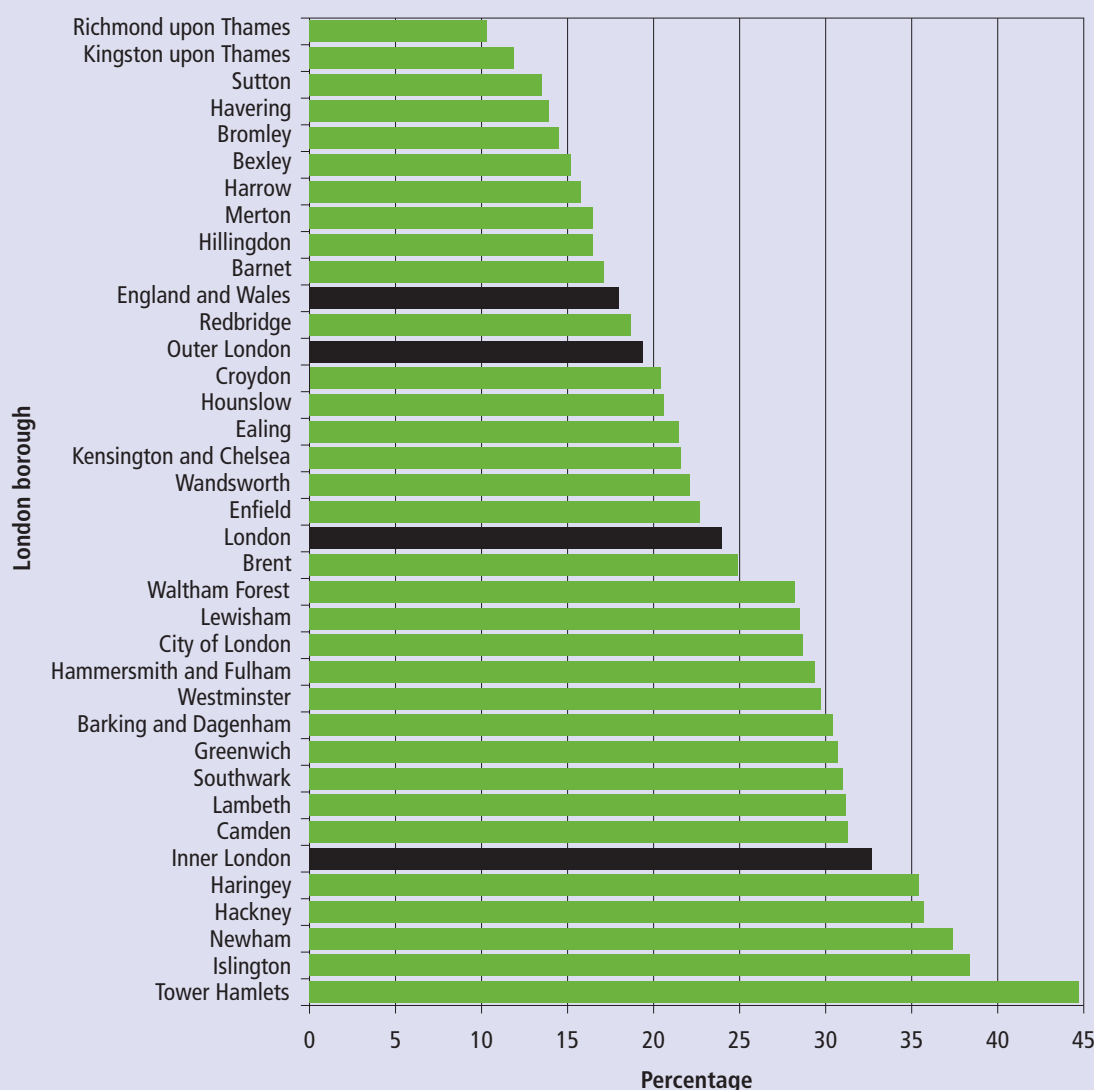
Young people can be affected by unemployment either on their own account, or as a result of being in a household with unemployed adults. Figure 8, which shows the percentage of dependent children in households with no adults in employment, demonstrates wide inequalities across London. A child in Richmond is least likely to live in a workless household, a child in Tower

Hamlets most likely. And despite media stereotypes and public perception of Islington, it has the second highest percentage of dependent children in workless households in London. This serves in part to illustrate the close proximity of the haves and have-nots within the capital.

Long-term unemployment has particularly debilitating health effects (as well as poor health being a cause of unemployment). It is therefore particularly worrying that such a high percentage of those completing the Census form in London, who have dependent children, have never been in work or are long-term unemployed. Figure 9 shows that London has a much greater proportion of households in these circumstances than the rest of England and Wales, and inner London has a particular problem.

Turning to young people themselves, Map 4 uses data from the *Labour Force Survey* (LFS) to show the percentage of 18-24 year olds who are not in employment or full time education. People aged over 16 are classed as employed by the LFS if they have done at least one hour of paid work in the reference week or are temporarily away from a job (e.g. on a holiday). Also included are people who do unpaid work in a family business and people on government-supported training and employment programmes.

At the regional level, London is fairly unremarkable in terms of the proportion of people aged 18-24 who are not in employment or full-time education – 16% – which is the same as the national average. In comparison the North East, at 21%, has the highest proportion (Figure 10). However, the London figure is skewed by the very high proportion of young people in full-time education

Figure 8 Percentage of dependent children with no adults in employment in the household

Source: 2001 Census, Theme Table TT01

(36%) rather than the proportion in employment, which, alongside the North East, is the lowest of all the English regions.

'Workless' households

It is important to bear in mind that many people who are not in paid employment do work (looking after their children for instance). We use the term 'workless households' to describe households with no adults in paid employment.

There were around 200,000 workless households with dependent children in London in 2001 representing 23% of all households with dependent children, compared to 17% in England and Wales. This was the highest rate for any region

of England, followed by the North East at 21%. Workless households with dependent children in London accounted for one in five of all such households in England. There are significant differences between the rates for inner London (31%) and outer London (18%). While the outer London figure is close to the national average, the inner London figure is far higher than for any English region.

Low levels of employment do not extend to households *without* dependent children in London, so there is a sizeable gap in rates of non-employment between households with and without children, which, in effect, widens inequalities.

Figure 9 Percentage of dependent children living in households where Household Reference Person has never worked or is long-term unemployed



Map 4 Proportion of young people aged 18-24 not in full-time education or employment, 2002

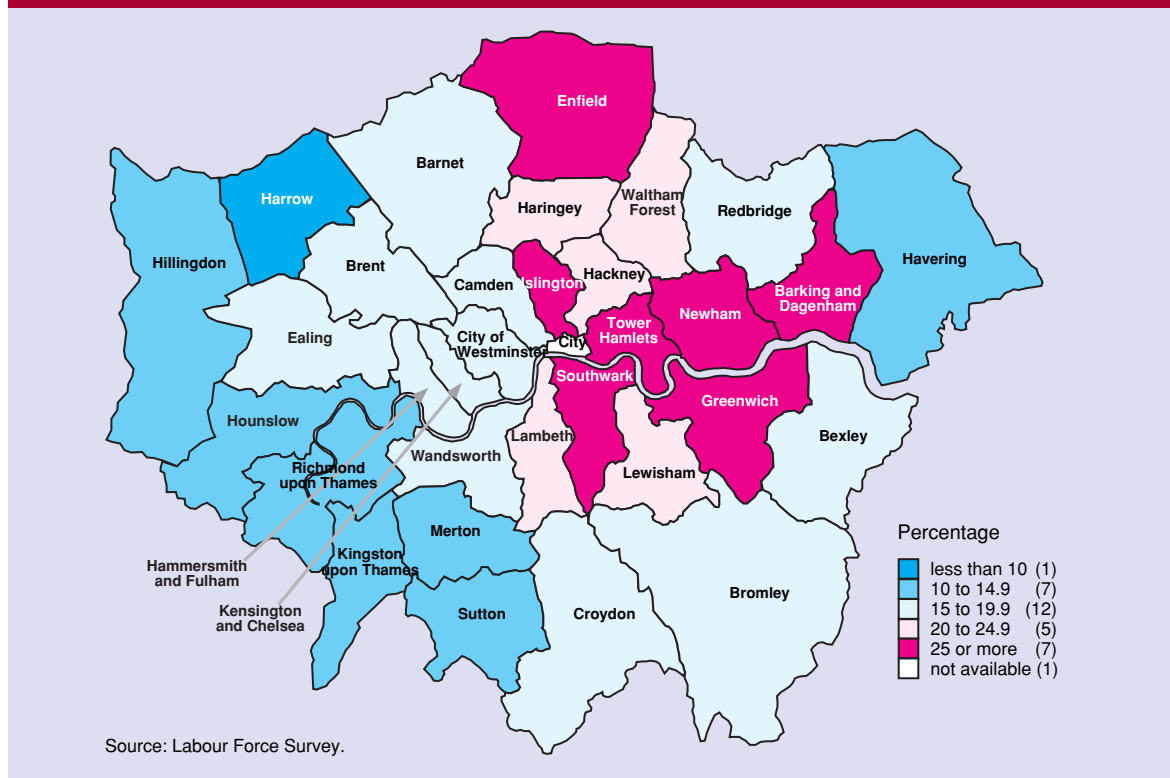
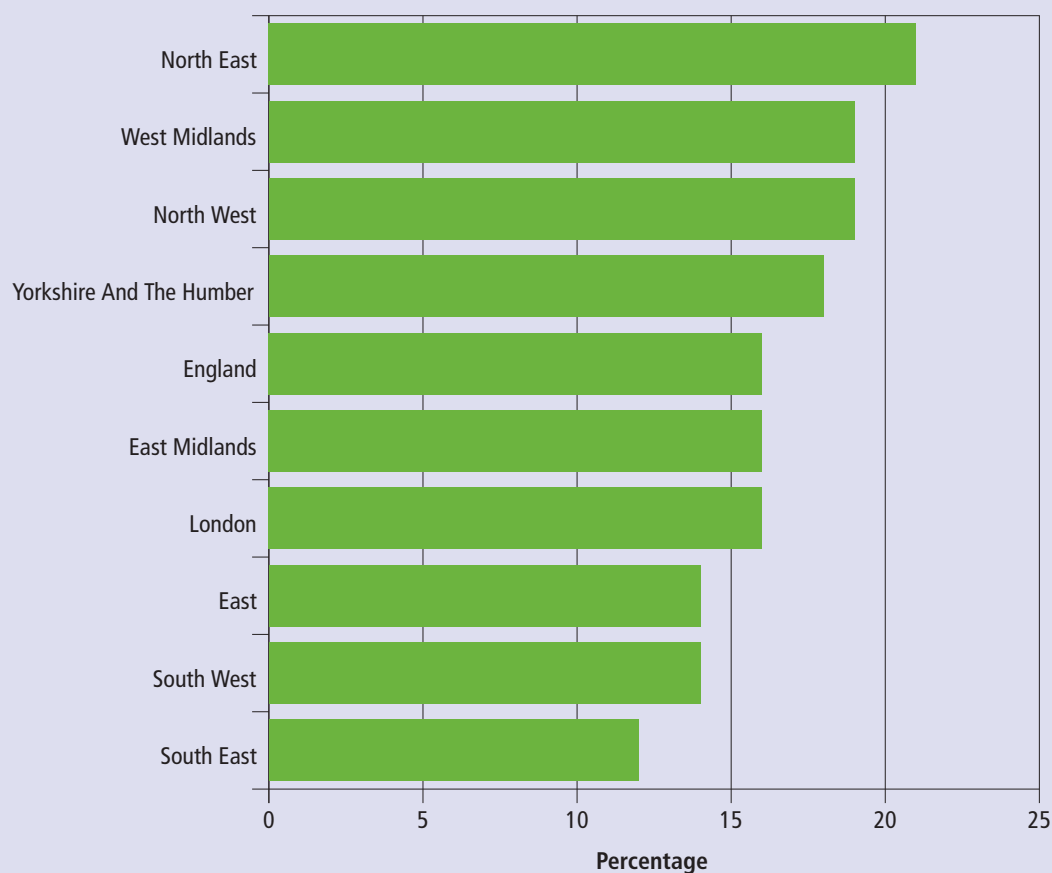


Figure 10 Percentage of people aged 18 to 24 not in employment or full time education

Source: 2001 Census, Standard Table ST028

Types of workless households with dependent children

Lone parents have lower rates of employment than other households with children, with 51 per cent of lone parent households being workless at national level. In London, and particularly inner London, the rate of worklessness is higher still, at 58% and 61% respectively. As lone parent households make up a high percentage of households with children in inner London, this goes some way towards accounting for levels of worklessness in inner London.

However, high levels of worklessness are also registered for non-lone parent households with children in London. At national level, 7% of these households have no adult in employment. In London, this was 10% and in inner London 16% (Table 7). At 30%, Tower Hamlets had by far the highest rate of worklessness for

non-lone parent households in London. While lone parents in inner London account for an important part of the difference in rates of worklessness among households with children between London and the national level, non-lone parent households account for more of the difference – about twice as much, in fact. This is because rates of non-employment for both groups are higher than the national level by around 10%, but there are around twice as many non-lone as lone-parent households.

Differences between areas

Maps 5 and 6 show workless households with dependent children in London, at ward level, as a percentage of all households and as a percentage of all households with dependent children respectively. They show that while the highest prevalence rates are in inner

Table 7 Percentage of households with no adult in employment by household type, 2001 (excluding pensioner-only households)

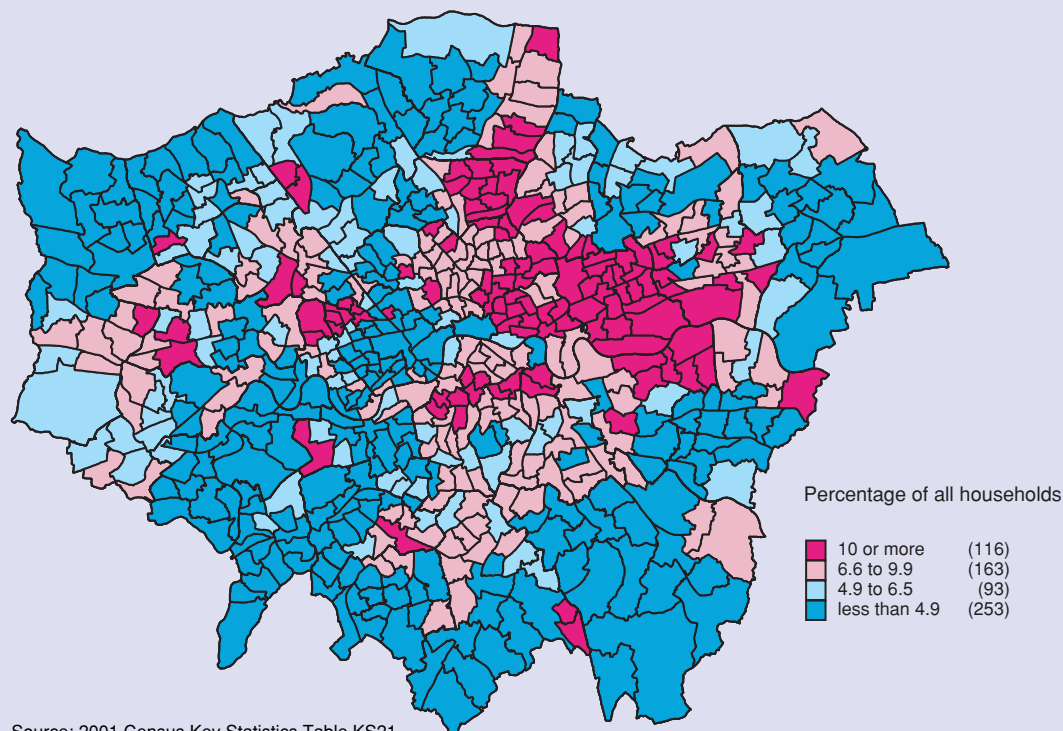
	All households	Households without dependent children	Households with dependent children	Lone parent households with dependent children	Non lone parent with dependent children
England & Wales	16.1	15.8	16.6	50.8	7.0
North East	23.4	25.0	20.9	54.1	10.1
North West	20.2	21.0	19.2	52.2	8.0
Yorkshire & Humber	18.1	18.6	17.4	50.5	8.0
East Midlands	15.1	15.3	14.8	48.0	6.2
West Midlands	17.1	16.7	17.6	51.7	8.0
East Of England	11.2	10.7	12.0	45.8	4.6
London	18.2	15.6	22.8	57.8	10.3
<i>Inner London</i>	<i>22.9</i>	<i>19.4</i>	<i>30.8</i>	<i>61.2</i>	<i>16.2</i>
<i>Outer London</i>	<i>14.7</i>	<i>12.5</i>	<i>18.2</i>	<i>55.0</i>	<i>7.4</i>
South East	10.1	9.3	11.3	44.7	4.0
South West	12.9	13.0	12.7	44.6	4.8
Wales/Cymru	21.5	22.5	20.0	54.4	9.1

Source: 2001 Census, Key Statistics, Tables KS20, KS21, KS22

London, there are also striking differences between areas in outer London.

Looking at the wider national picture, Table 8 shows the 20 local authority districts in England which have the highest percentages of workless households with dependent children. London accounts for 13 of these districts and, as can be seen, the disparities in rates of worklessness between households with and without dependent children are far more marked in the London boroughs than elsewhere.

Map 5 Households with no adults in employment and with dependent children as a percentage of all households



Map 6 Households with dependent children with no adult in employment as a percentage of all households with dependent children

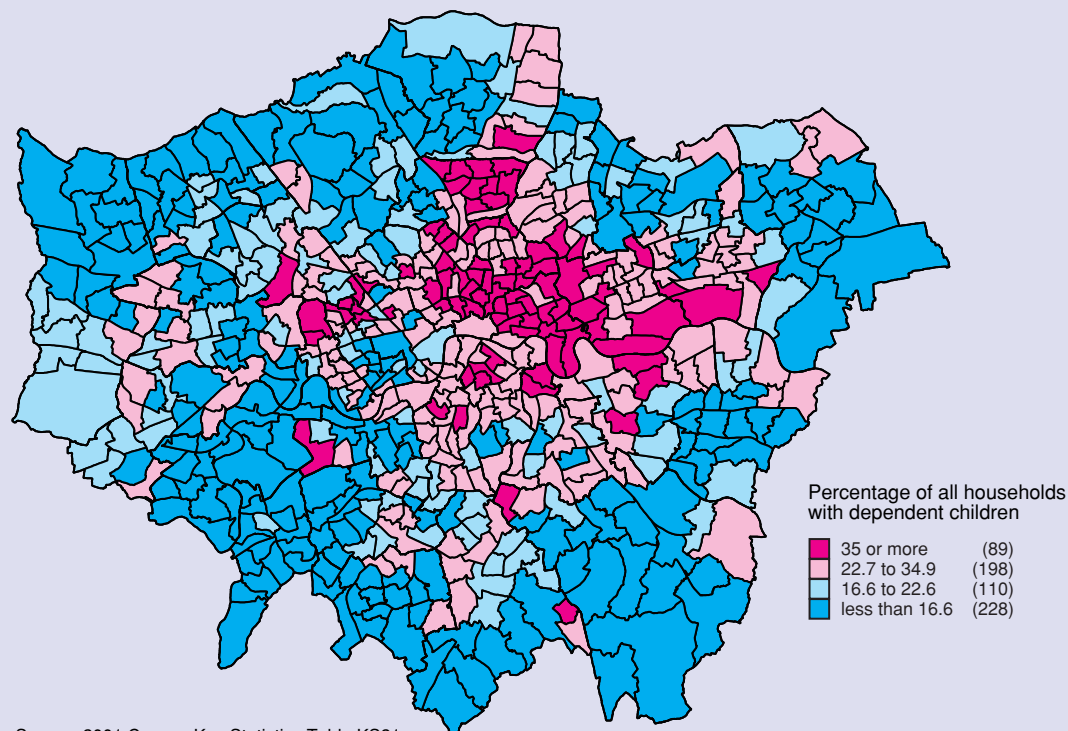


Table 8 Percentage of households with no adult in employment by household type, 2001 (excluding pensioner-only households)

	% households without children	% households with children
Tower Hamlets	22.2	41.5
Islington	23.3	36.9
Manchester	31.0	35.9
Hackney	25.2	35.6
Newham	26.4	34.9
Liverpool	34.9	34.5
Haringey	19.8	33.3
Nottingham UA	27.5	32.2
Knowsley	33.1	31.3
Southwark	20.7	29.7
Lambeth	18.2	29.7
Camden	21.0	29.7
Greenwich	21.1	29.1
Barking and Dagenham	19.7	28.7
Middlesbrough UA	31.6	28.2
Westminster	18.4	27.8
Hammersmith and Fulham	16.3	27.8
Birmingham	24.5	27.6
Kingston upon Hull, City of UA	26.2	27.3
Lewisham	17.4	26.9

Source: 2001 Census, Key Statistics Table 20

Indicator 2 – Ethnicity and unemployment

The child population of London is far more ethnically diverse than at national level, reflecting not only the overall higher percentage of ethnic minority residents in London but also the younger age structure of most minority populations. Only 52% of London's dependent children belong to the White British group, compared to 91% of children in the rest of England and Wales. Irish and 'Other' White groups bring the White total up to 59% of London's child population. Two-fifths of London's dependent children thus belong to a Black or Minority Ethnic (BME) group (excluding those who belong to white minority groups), compared to 9% nationally. In inner London, 53% of dependent children are from a 'non-white' group.

Asian and Black groups make up similar percentages of dependent children at Greater London level at 16% and 15% respectively. The largest individual groups in London other than White British are Indian (9%) and Black African (7%).

While Black/Black British groups make up much higher percentages of the population in inner than in outer London, it is important to recognise that some 42% of all Black/Black British children, and 45% of Black Caribbean children are living in outer London. 7% of dependent children in London are of mixed parentage, rising to 8% in inner London. At national level, mixed groups account for only 3% of dependent children.

Household level data by ethnic group is not currently available, so in order to see how worklessness among households with children affects different ethnic groups, it is necessary to look at children

living in workless households rather than workless households with children.

Key Findings

- 20% of White children in London were in workless households, a significantly higher percentage than national level (16%) (2001 Census).
- All Black groups had more than 30% of children living in workless households, as did all mixed White and Black groups.
- Those with the highest proportions of children in workless households were the mixed White/Black Caribbean group, the Bangladeshi group (both at 40%) and the Black African group (39%).
- The percentage of Indian children in workless households in London was far smaller than any other ethnic group.
- There were large ethnic group differences between inner and outer London, with inner London children at far greater risk of being in a workless households in most cases.
- Recent data from the *Labour Force Survey* (Autumn 2004) reveals that BME children comprise 58% of all London's children living in workless households.

Children in workless households by ethnicity

24% of all children in London were living in workless households on Census Day in 2001. There were striking disparities between ethnic groups, and within many groups there were also disparities between inner and outer London rates (Table 9). 20% of White children in

London were in workless households, a significantly higher percentage than national level (16%). All Black groups in London had more than 30% of children in workless households, as did all mixed White and Black groups. The groups with the highest percentages of children in workless households were the mixed White/Black Caribbean group at 40%, and the Black African group at 39%.

40% of Bangladeshi children, 29% of Pakistani children and 24% of Chinese children were in workless households in the capital. At 11%, Indian children were the only Asian group to have a lower risk of being in a non-employed household than White children.

With the exception of the Black African group, the percentages of children in workless households were lower for all groups in outer London, although the difference between inner and outer London varied between groups. In inner London, 27% of White children were in workless households, compared to 17% in outer London. While Black African children were no less likely to be in workless households in outer London than in inner London, there was a 12

percentage point difference for Black Caribbean children (25% in workless households in outer London compared to 37% in inner London). This difference was even greater for Chinese, Bangladeshi and Irish children. Indian children in inner London were twice as likely to be in workless households as those in outer London.

These figures show that, for some groups at least, there are significant differences in the risk of being in a workless household between areas of London. In some cases, groups are particularly concentrated in either inner or outer London. The great majority of Bangladeshi children are in inner London, meaning that the lower risk of worklessness in outer London impacts on a very small proportion of the population. In other cases, including Black Caribbeans, the population is more evenly divided between inner and outer London, so that differences in rates of worklessness between inner and outer London carry more weight. Figure 11 illustrates the extent to which children from London's minority ethnic groups were in workless households in 2001.

Figure 11 Percentage of children in workless households by ethnicity, 2001

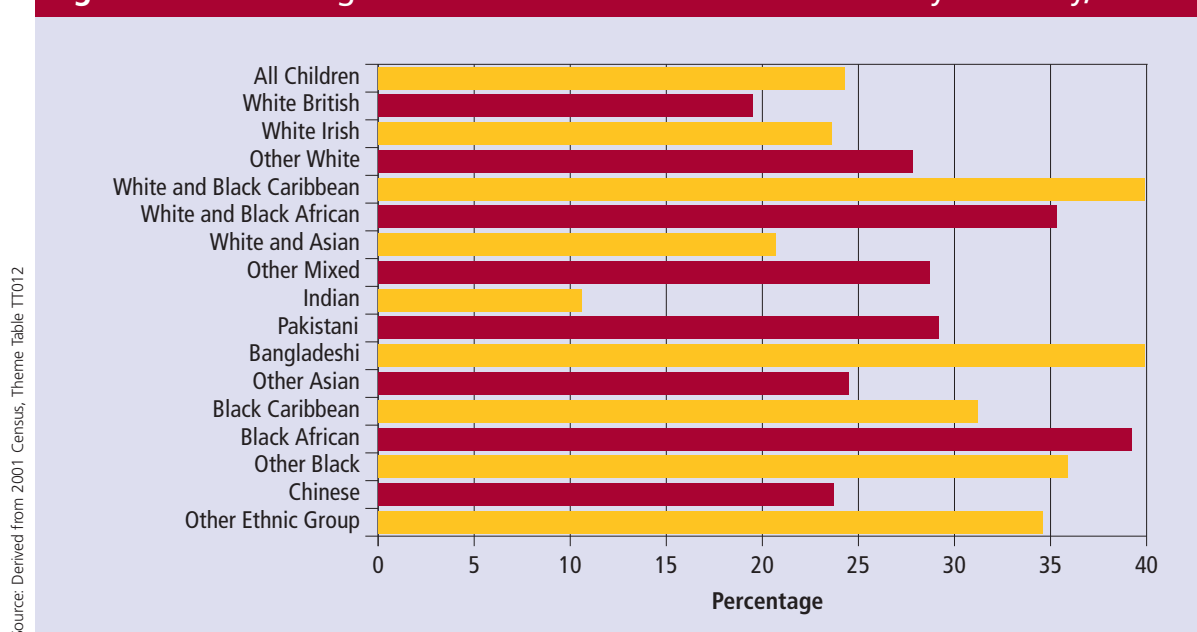


Table 9 Percentage of children in workless households by ethnicity, 2001

	Inner London	Outer London	London	Rest of England & Wales
All Children	32.7	19.4	24.3	16.5
White	27.5	17.3	20.4	15.6
British	26.6	16.9	19.5	15.6
Irish	34.5	17.9	23.6	18.7
Other White	31.2	24.2	27.8	16.3
Mixed	37.9	27.1	31.9	29.1
White & Black				
Caribbean	44.7	35.4	39.9	36.0
White & Black				
African	37.6	32.8	35.3	31.1
White & Asian	26.8	17.5	20.7	22.4
Other Mixed	35.0	23.5	28.7	23.0
Asian or Asian British	36.0	15.5	23.4	24.4
Indian	19.7	8.7	10.6	12.1
Pakistani	34.1	27.1	29.2	31.1
Bangladeshi	42.5	24.5	39.9	32.4
Other Asian	33.9	21.1	24.5	27.4
Black or Black British	37.9	33.5	36.0	31.2
Black Caribbean	36.5	24.6	31.2	28.9
Black African	38.4	40.5	39.2	34.8
Other Black	39.3	30.8	35.9	32.4
Chinese or Other				
Ethnic Group	38.4	24.4	30.5	19.7
Chinese	35.0	14.7	23.7	13.6
Other Ethnic Groups	40.5	30.2	34.6	28.9

Source: Derived from 2001 Census, Theme Table TT012

Indicator 3 – Educational attainment: percentage of pupils achieving GCSE grades A*–C

Education plays a number of roles in influencing inequalities in health, if health is viewed in its widest sense. It has an important role in influencing inequalities in socio-economic position. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources. These are related to health and health inequalities. As a consequence, education is a traditional route out of poverty for those living in disadvantage.

Children from disadvantaged backgrounds, as measured by being in receipt of free school meals, have lower educational achievement than other children (Acheson, 1998).

This indicator shows the percentage of pupils aged 15 achieving 5 GCSEs at grades A*–C or equivalent. This includes GCSEs, GCSE Short Courses, Part One GNVQs, Full GNVQs, and GNVQ Language Units. Pupils must have been 15 at the start of the academic year to be counted. This indicator uses results from maintained schools only. The data is shown at Local Education Authority level, based on where the pupil goes to school rather than where they live.

Since the entire focus of the report this year is on children and young people, we also include data from earlier in the child's educational career. There is strong evidence from the UK cohort studies that some of the most important protective factors for children in the long term are to do with education. The ability to read is a liberating experience

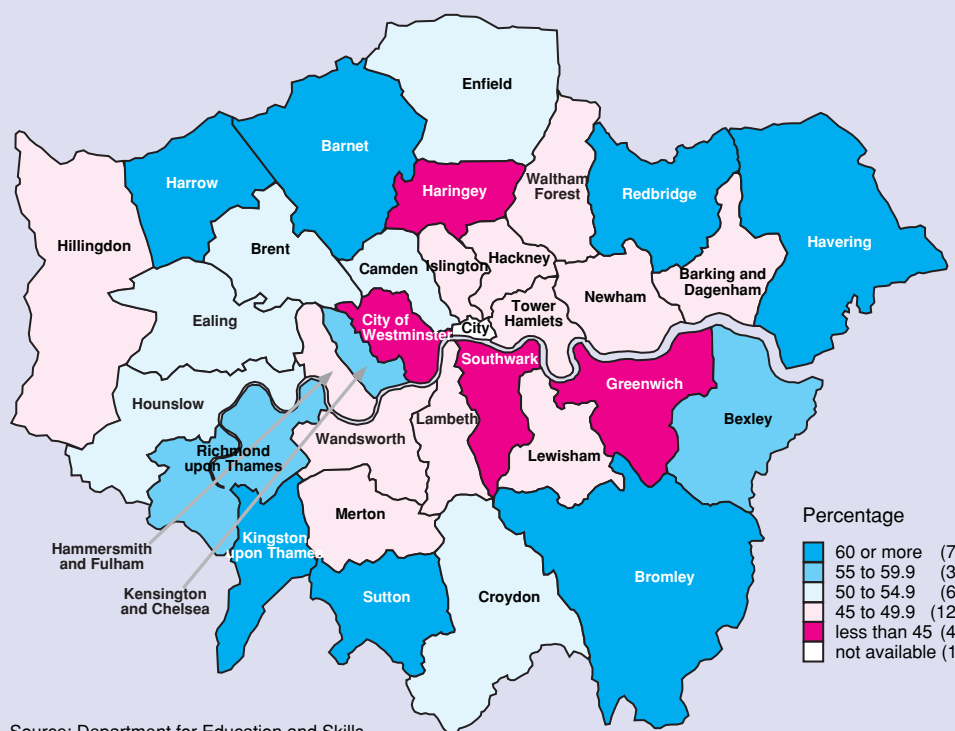
for children, helping them to explore other worlds. We therefore include below information on earlier stages in a child's educational career.

Table 10 Top performing local authorities (added value measure >100.4) on Key Stage 1 to Key Stage 2 Value Added Measures for 11 year olds in England 2003/2004 (Revised)

Blackpool	100.4
Rutland	100.4
Islington	100.4
Richmond upon Thames	100.4
Bracknell Forest	100.4
Dorset	100.4
Hammersmith and Fulham	100.5
Tower Hamlets	100.5
Harrow	100.5
Wokingham	100.5
Lambeth	100.6
Ealing	100.6
Trafford	100.7
Camden	100.7
Enfield	100.7
Hounslow	100.7
Barnet	100.8
Newham	100.9
Kingston upon Thames	100.9
Westminster	101.0
City of London	101.4
Kensington and Chelsea	101.4

Source: Department for Education and Skills

Map 7 Percentage of 15 year olds achieving 5 or more GCSEs at grades A*-C, 2003/04



Key findings

- In London, 53% of children aged 15 achieved five or more GCSEs at grades A*-C in 2004, a similar proportion to the England average (52%)
- At borough level, the proportions ranged from 40% in Greenwich to 68% in Redbridge
- Results at Key Stages 1, 2 and 3 have improved in London between 1998 and 2004, although performance in inner London is generally below nationally expected levels.

Trends in educational attainment

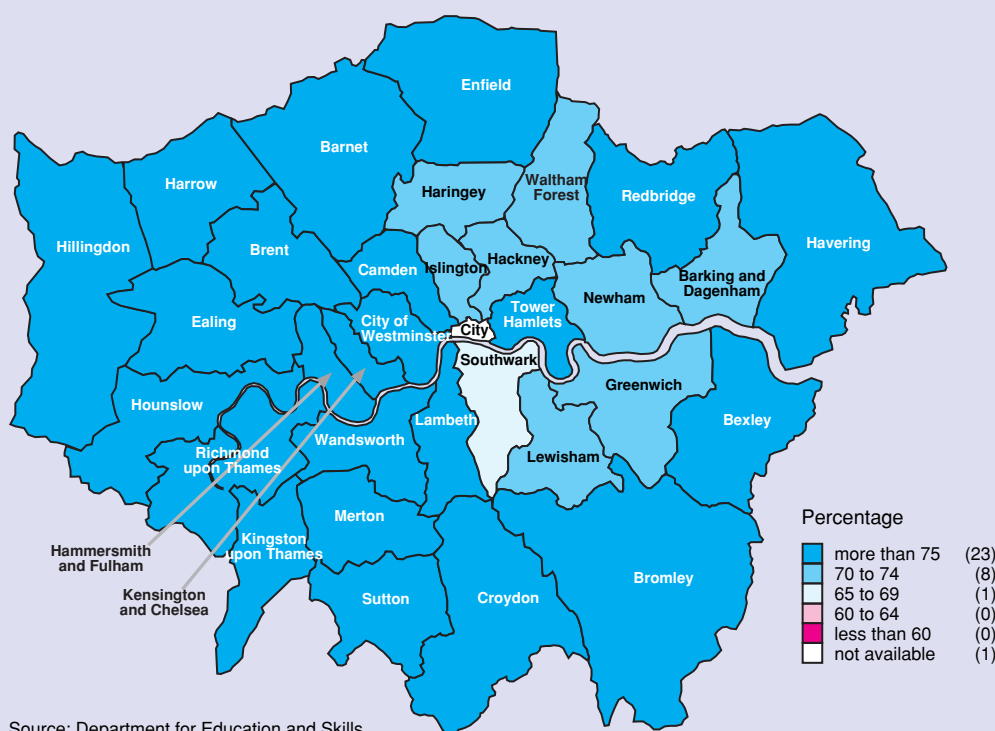
Last year's *Health in London* report provided information on changes in GCSE performance at London and national levels, revealing that much of London's improvement was due to the improved performance of inner London pupils. Results for pupils achieving GCSE grades A*-C in 2004 show that this improvement is being sustained.

In the maintained sector, the percentage of pupils in London achieving five or more GCSE grades A*-C increased from 51% in 2003 to 53% in 2004. While there was only a modest improvement in outer London over this period (around one percentage point – similar to the improvement in England overall), in inner London there was a four percentage point increase in performance. The gap between inner and outer London now stands at around eight percentage points, narrowing from 11 points in 2003 and 14 points in 1998.

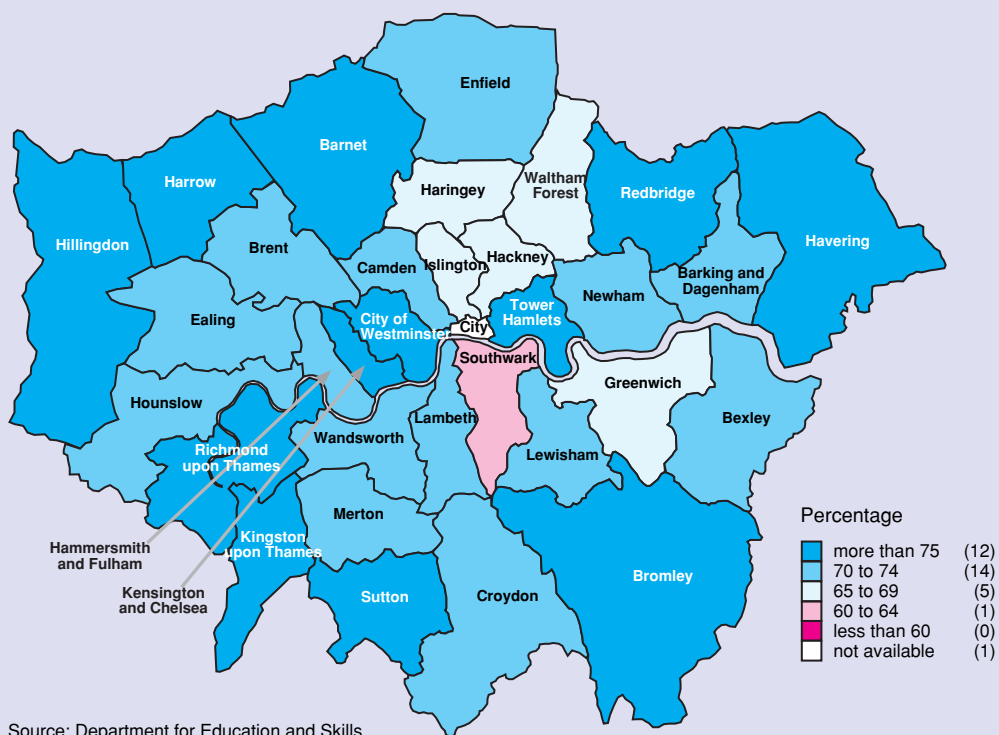
Across London results for five or more GCSEs grades A*-C ranged from 40% in Greenwich to 68% in Redbridge. Map 7 clearly demonstrates that, despite the closing gap, there is a greater likelihood in most outer London boroughs of obtaining good GCSE results, compared to those in inner London.

Turning to educational attainment in earlier years, performance at Key Stage 1 (KS1) in London has been below the

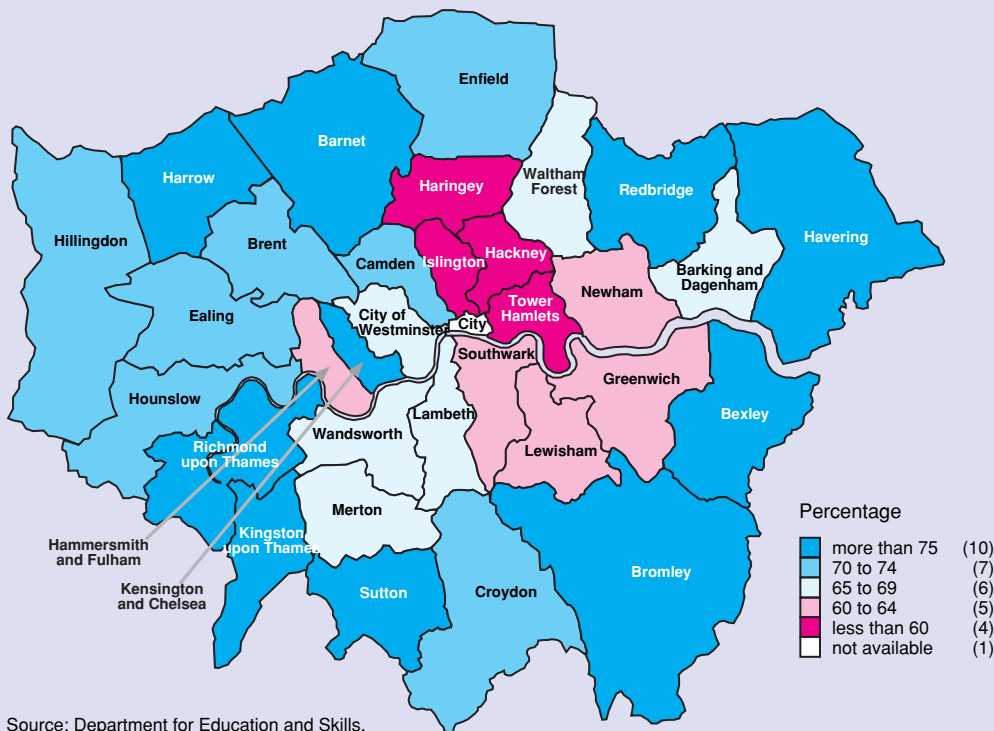
Map 8 Percentage of pupils achieving level 4 or above at Key Stage 2 English, 2003/04



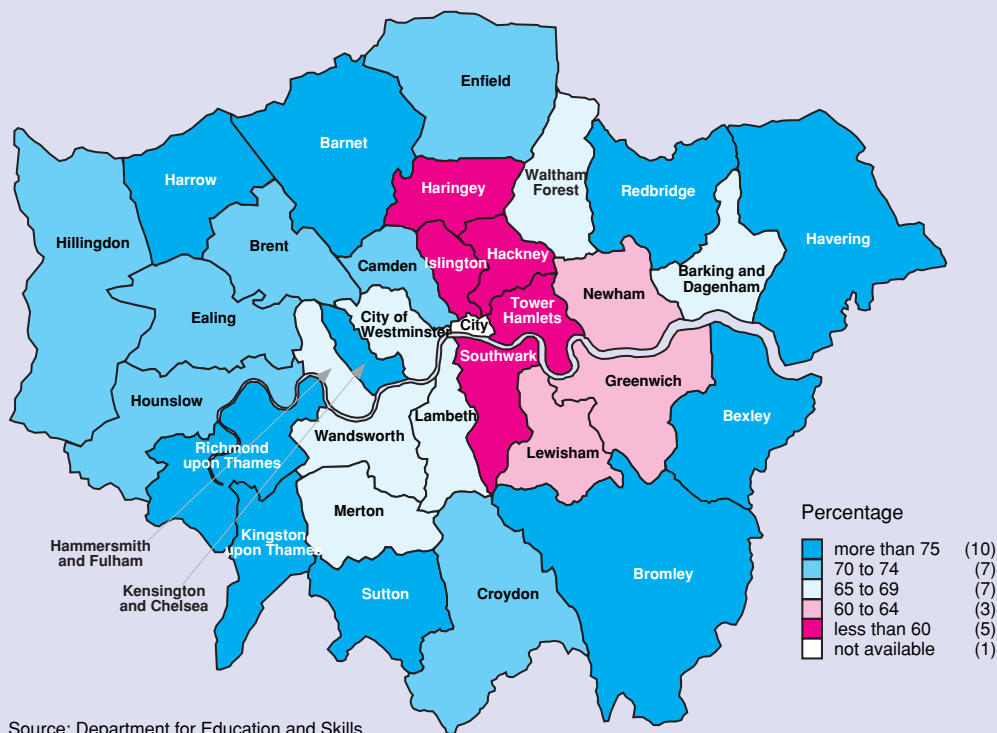
Map 9 Percentage of pupils achieving level 4 or above at Key Stage 2 Maths, 2003/04



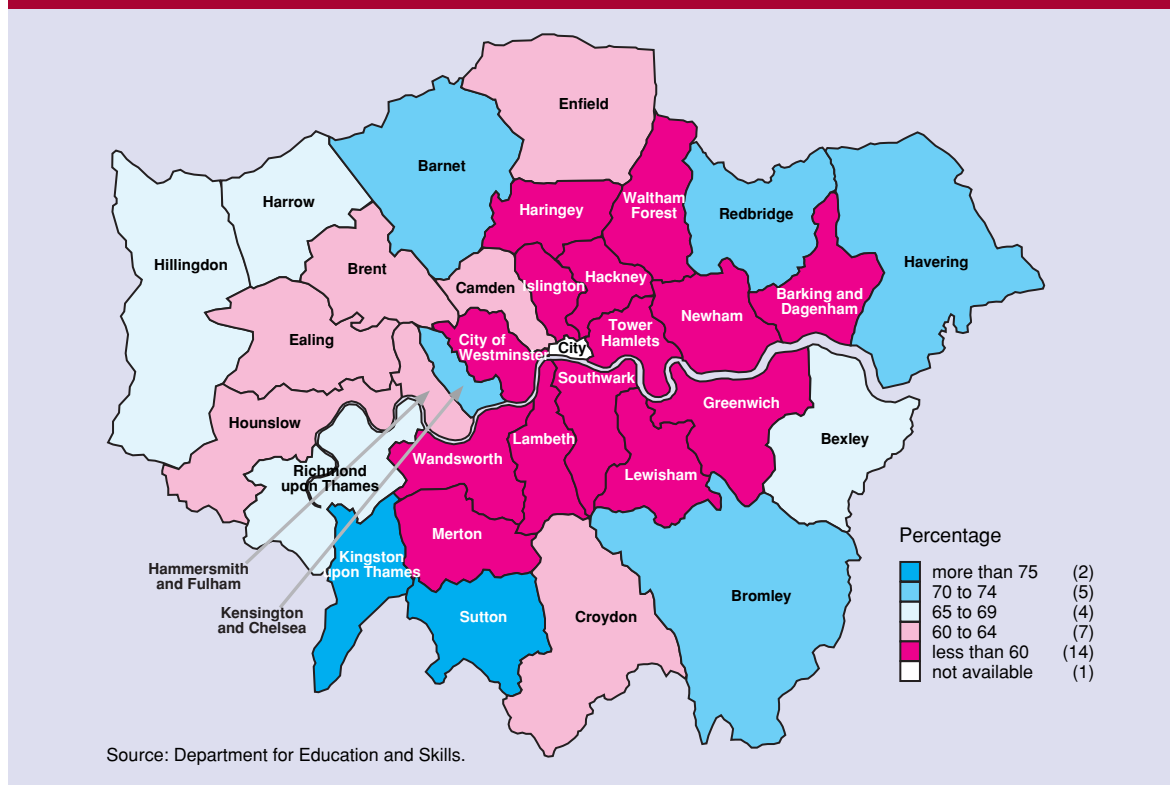
Map 10 Percentage of pupils achieving level 5 or above at Key Stage 3 English, 2003/04



Map 11 Percentage of pupils achieving level 5 or above at Key Stage 3 Maths, 2003/04



Map 12 Percentage of pupils achieving level 5 or above at Key Stage 3 Science, 2003/04



national average on reading, writing and mathematics tests in every year since 1999. In outer London the performance of pupils has been below the national average, but less so than in inner London.

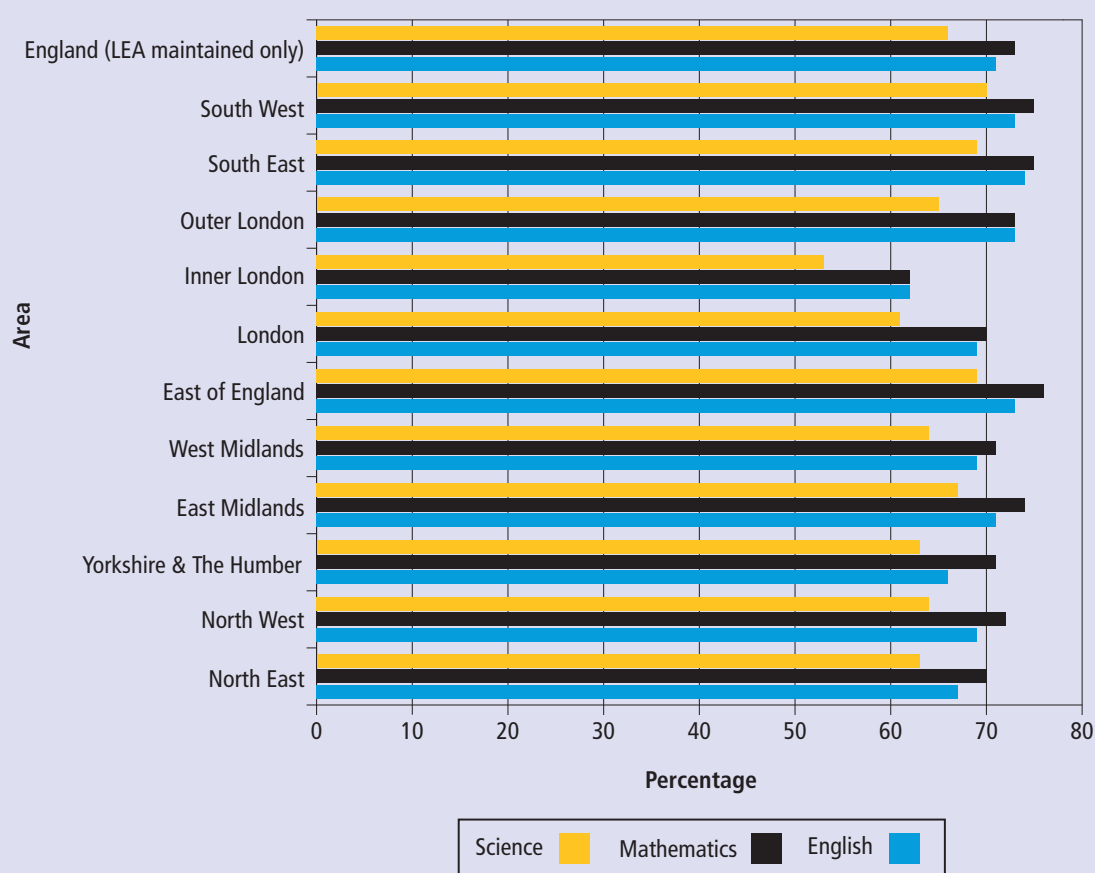
Key Stage 2 (KS2) results have shown a pronounced pattern of improvement over the period 1998 to 2004. In 2004, 76 per cent of pupils achieved level 4 in the English test compared to 77 per cent in England overall. The outer London performance (78 per cent) was as high as the top performing regions. In mathematics, inner London performance, while continuing to improve, was still far below the performance in other areas of the country.

Key Stage 3 (KS3) performance also improved in the period 1998-2004. Performance in outer London was close to the national averages for English, mathematics and science. Although there have also been improvement across all disciplines from earlier years, the

results in inner London are around 10% below the nationally expected levels.

Figure 12 indicates how London fared against the other English regions and the national average at Key Stage 3 level in 2004. It graphically illustrates the gap between outer London, which was close to the national average in all three subjects, and inner London, which was by far the worst (sub) regional performer across the board.

For the Value Added (VA) measures used in the primary and secondary performance tables, pupils are placed into groups according to their average prior attainment at the end of the previous key stage. The median result for each group is then calculated. A pupil's VA score is derived by taking the pupil's result and subtracting the median for their group. Pupils achieving above the median therefore have positive scores while pupils below the median have negative scores. School scores are

Figure 12 Percentage of pupils achieving level 5 or above in the 2004 Key Stage 3 tests

Source: Department for Education and Skills, Research & Statistics

calculated by taking the average of the scores for the pupils within the school, and finally adding 100. LEA and national scores are calculated from pupil scores in the same way as school scores. The national average is close to, although not necessarily exactly, 100.

Table 10 shows that, of the top 22 local authorities that had an VA measure greater than 100.4 on KS1 to KS2 in 2003/04, 15 were London boroughs, and nine of these inner London boroughs. However, the impressive performance in London between KS1 and KS2 is not maintained between KS2 and KS3. Only nine London boroughs scored greater than 100 on this measure – none of these were inner London boroughs. Maps 8-12 show how differentials within London at Key Stage 2 have become even more pronounced at Key Stage 3.

Ethnicity and educational achievement

There are major differences in the educational attainment of different Black groups, particularly when socio-economic factors are taken into account. For further details on GCSE performance and a range of other differentials such as social class, English as an Additional Language (EAL), and underachieving groups, we refer readers to the extensive commentary contained in last year's report (see www.londonhealth.gov.uk/hinl.htm).

Nationally, Pakistani, Black Caribbean, Black African and other pupils with black backgrounds are over-represented in the low attaining group on KS2 tests. Low attainment is defined as the bottom quartile (25%) of pupils in terms of average points at each Key Stage. The probability of being able to move out of

a low attaining group between KS2 and KS4 varies between ethnic groups. For example, for Indian and Bangladeshi pupils starting in the low attaining group at KS2 in 2000, and again at KS3 in 2002, 51% were able to move out of this group at KS4. For Pakistani and Black Caribbean pupils, the equivalent figures were 43% and 31%, while White British pupils – at 25% – were the least likely to move out of the low attaining group (DfES, 2005).

Indicator 4 – Proportion of homes judged unfit to live in

This section deals largely with overcrowding, but also considers children who are living in temporary accommodation. Earlier *Health in London* reports (see <http://www.londonhealth.gov.uk/hinl.htm>) provide broader information on unfit housing.

The effects of overcrowding on the health and well-being of household members has been well documented. Overcrowding has been associated with a range of physical problems in adults such as respiratory disorder, short stature, heart disease, stomach cancer and other cancers. It has also been linked to the development of emotional problems in children, and links with aggression and poor mental adjustment. Infections such as chickenpox, mumps, measles, the common cold and tuberculosis (TB) are also more prevalent in overcrowded conditions. (*Health of Londoners Project 1998*)

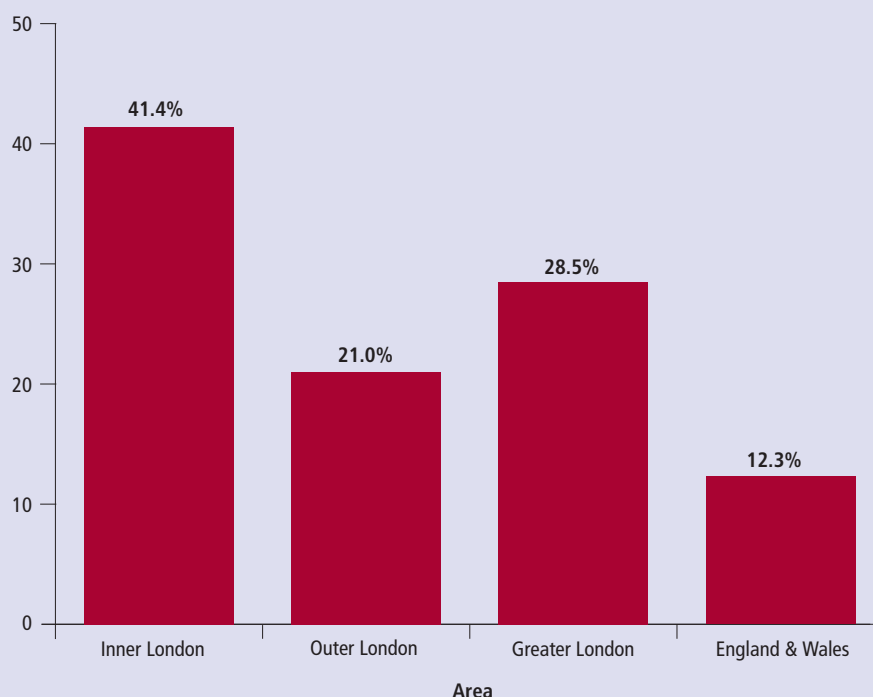
Overcrowding in childhood may contribute to a higher risk of respiratory disease in adulthood and significantly increases the likelihood of people rating their health as 'poor' in adulthood.

Having no quiet place to study can have a severely detrimental impact on

Table 11 Dependent children in overcrowded households by age group

	Number						%
	All	All	0-4	5-9	10-14	15-18	
Inner London	247,712	41.4	40.2	39.3	42.4	46.4	
Outer London	213,992	21.0	21.0	18.8	21.1	24.3	
London	461,704	28.5	28.7	26.3	28.7	32.0	
England & Wales	1,431,657	12.3	11.8	10.6	12.8	15.0	

Source: 2001 Census Theme Table TT01, Crown Copyright

Figure 13 Dependent children living in overcrowded housing

Source: 2001 Census, Theme Table TT01

educational attainment. Lack of space resulting from overcrowding can make homework and revision more difficult. One study in New York found that overcrowding increased the likelihood of not finishing secondary education by 11% among boys and 6% among girls (London Housing, 2004).

Key findings

- England's ten worst local authority areas for overcrowding are all in London.
- 29% of all dependent children in London were living in overcrowded conditions in 2001, compared with 12% in England and Wales.
- A high proportion of London's dependent children live in accommodation rented from a local authority or registered social landlords, tenures which have seen particularly high increases in overcrowding between 1991 and 2001.

Overcrowded housing

Overcrowding in London increased by 20% in the ten years between 1991 and 2001. One in twenty households (150,000) are now overcrowded (over 1.0 and up to 1.5 persons per room) and 61,000 households, 2% of the London total, are now severely overcrowded (more than 1.5 persons per room). In contrast, severe overcrowding has decreased by 9% in the rest of England (London Housing, 2004a). England's ten worst local authority areas for overcrowding are all in London (London Housing Federation, 2004).

In the council sector, overcrowding has increased by nearly 50% over this period and has now overtaken the private rented sector as the tenure with the highest rate of severe overcrowding. Severe overcrowding increased in council housing in every London borough between 1991 and 2001. Increases in overcrowding in the housing association sector were also as high as for council housing. The increase in overcrowding in London reverses a long-term decline that

Table 12 Dependent children in overcrowded households by ethnic group %

	Inner London	Outer London	London	England	England & Wales
All Dependent Children	41.4	21.0	28.5	12.5	12.3
White British	25.8	13.2	16.6	9.0	8.9
White Irish	30.8	17.8	22.2	15.8	15.7
Other White	38.4	24.2	31.5	20.1	19.8
White and Black Caribbean	37.7	23.1	30.2	19.0	18.8
White and Black African	46.2	33.6	40.1	26.0	25.7
White and Asian	33.7	19.0	24.0	15.1	15.0
Other Mixed	40.8	22.7	30.9	19.1	19.0
Indian	43.0	28.7	31.2	25.5	25.5
Pakistani	49.6	38.7	42.0	36.2	36.0
Bangladeshi	68.5	48.5	65.6	56.1	55.6
Other Asian	55.8	44.1	47.2	39.7	39.5
Black Caribbean	41.3	27.8	35.2	29.9	29.9
Black African	63.7	52.1	59.1	55.3	55.1
Other Black	50.7	35.4	44.6	37.6	37.5
Chinese	47.4	27.3	36.2	29.5	29.5
Other Ethnic Group	53.4	35.0	42.9	35.5	35.2

Source: 2001 Census Theme Table TT012, Crown Copyright

mirrors the population change in the capital (London's population fell to 6.8 million in 1983 but has been growing steadily since 1989).

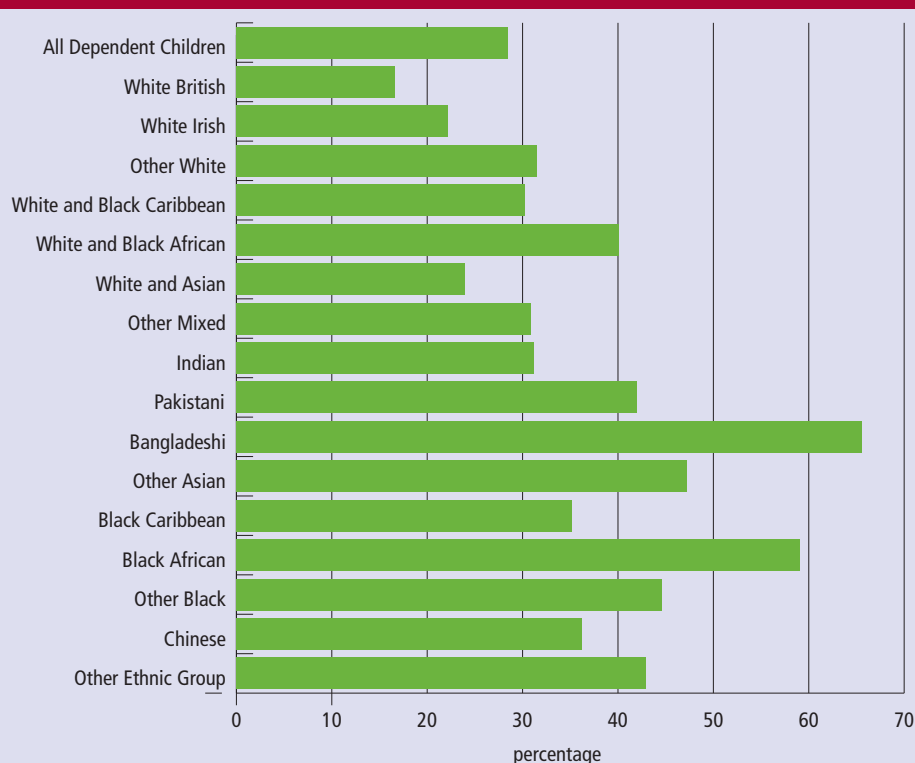
Around 460,000 children in London were living in overcrowded conditions on Census day in 2001, representing 28.5% of all dependent children, compared to an England and Wales figure of 12.3%. Despite having a smaller child population, more children in inner London were living in overcrowded conditions than in outer London, although the proportion of children living in such housing was significantly higher than the national

figure in both inner and outer London. Overcrowding among children in inner London was more than three times the national average.

Overcrowding reaches a peak among those aged 15-18. In inner London, nearly half of all children in this age group were living in households without enough rooms.

Overcrowding and ethnicity

Some ethnic groups are more likely to experience overcrowding than others. Bangladeshi households are over five times more likely to live in overcrowded conditions than White British

Figure 14 Dependent children in overcrowded households by ethnic group, London 2001

Source: 2001 Census, Theme Table TT012

households. Over half of Black African households, two-fifths of other Black households and 38% of Pakistani households suffer from overcrowding.

As Table 12 and Figure 14 show, around two-thirds of Bangladeshi children in London were living in homes that were overcrowded on the occupancy measure in 2001 – four times the rate for White British children. As the vast majority of Bangladeshi children live in inner London, the lower rate in outer London does not have a significant effect on the London figure. Three-fifths of Black African children were also living in overcrowded conditions, while rates for Mixed White and Black African, Pakistani, Other Asian and Other Black children were all over 40%. Across all ethnic groups, rates of overcrowding among children were significantly higher in inner London than in outer London.

Overcrowding at borough level

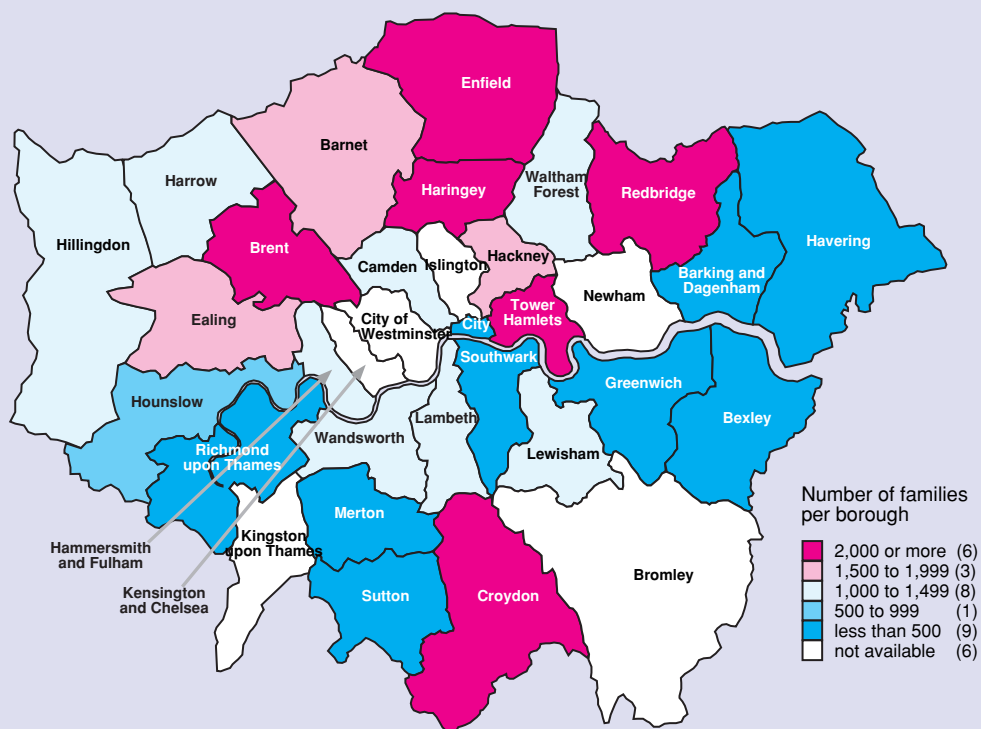
In 2001, the worst overcrowding in London was generally found north of

the Thames, particularly in a wide swathe of wards across east and north-east London. Unsurprisingly perhaps, the spatial distribution of overcrowding at ward level corresponds with the pattern for other deprivation indicators in London, such as receipt of means-tested benefits. However, significant pockets exist in other parts of the capital, particularly in west London and south of the river in Southwark and Lambeth (London Housing, 2004b).

The worst levels of overcrowding to be found in England are in the London borough of Tower Hamlets, where a third of the population is Bangladeshi. Tower Hamlets is home to six of the ten most crowded wards in London. The other four are in Newham and Ealing. Map 13 shows the distribution of children living in overcrowded homes at London borough level. More than 40% of children in the boroughs of Tower Hamlets, Newham, Hackney, Southwark, Westminster, Islington and Camden were living in overcrowded conditions.

Map 13 Dependent children living in overcrowded housing

Source: 2001 Census Theme Table TT012.

Map 14 Homeless families with dependent children living in temporary accommodation (Oct-Dec 2004)

Source: Office of the Deputy Prime Minister, P1E Homelessness Returns.

At 63%, Tower Hamlets is the only London borough where more than half of dependent children live in overcrowded conditions.

After a long period of decline, tuberculosis (TB) is on the rise again in the capital. Research by London Housing has shown a strong correlation between the incidence of overcrowding among London boroughs and the distribution of TB notifications in 2001. The research revealed that all but three of the boroughs with above average levels of overcrowding also had above average incidence of TB. While academic research has consistently linked the rise in TB notifications in London to patterns of migration, overcrowding had been identified as a more significant factor.

Homeless families living in temporary accommodation

22% of all households that were accepted as homeless by local authorities in England in 2003/04 were in London. In that year, there were nearly 69,000 decisions on homelessness applications in London, of which 30,500 (44%) were accepted as homeless. 58% of households accepted as homeless came from Black and Minority Ethnic groups despite representing only 29% of London's population (*Housing in London*, 2005). Over the period 1999-2000 to 2003-04 homeless acceptances in London grew by 7%. Two thirds of households accepted as homeless in 2003-04 contained dependent children and/or a pregnant member of the household (ODPM). The total number of London homeless households in temporary accommodation (excluding the homeless at home) rose for the fifth consecutive month to 63,282 by the end of March 2005 (GLA, 2005).

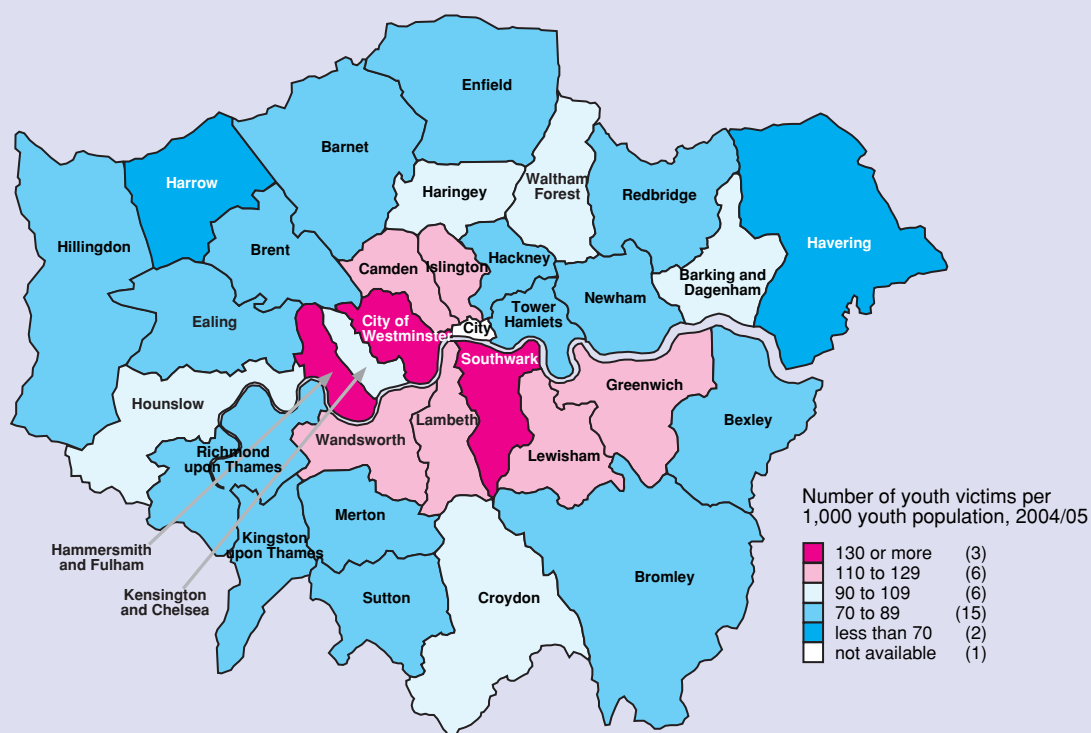
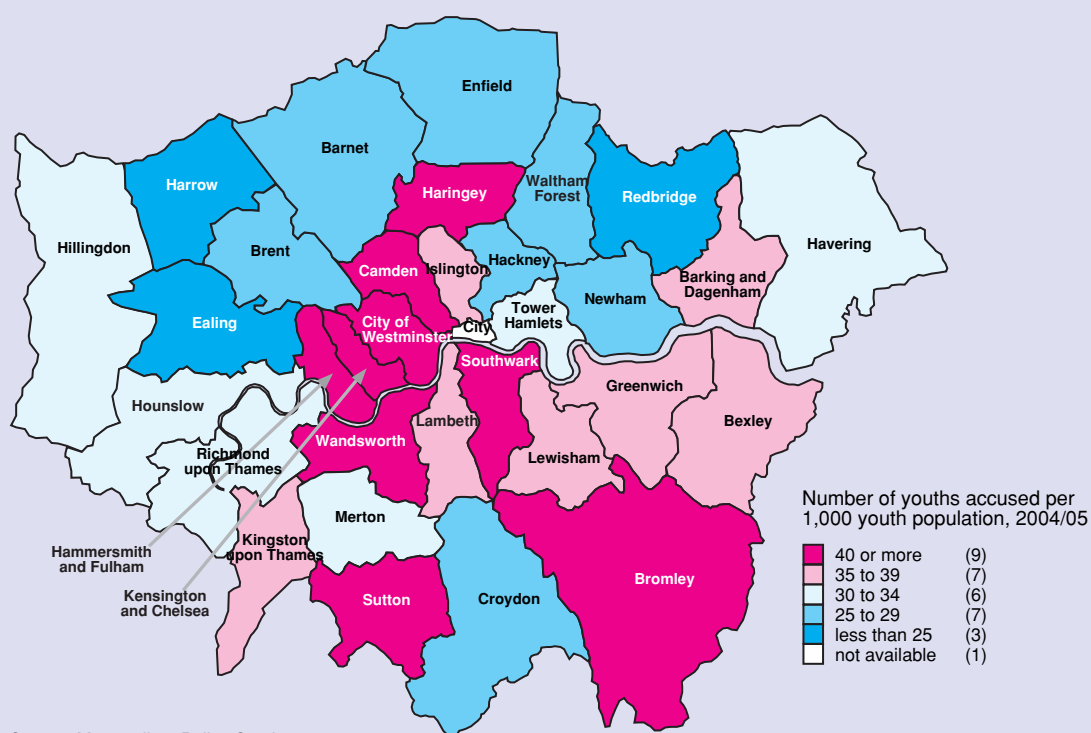
There is clear evidence of a link between temporary accommodation and an

increase in the prevalence of mental health and respiratory problems. Conditions in temporary accommodation are often very poor with little privacy or security and shared kitchens and/or bathrooms. The accommodation may be damp, cold and overcrowded. Poor quality temporary housing has been associated with a number of health risks including respiratory and gastrointestinal infections, poorer perinatal outcomes and mental health problems linked to stress. It has also been associated with unintentional injury (Acheson, 1998).

In response to a questionnaire Shelter sent to 2,000 homeless families living in temporary accommodation, over a half said that their health or their family's health had suffered. Children had missed an average of 55 school days due to disruption caused by moves between temporary accommodation and two thirds of respondents said their children had problems at school. Nearly half described their children as 'often unhappy or depressed' (Shelter, 2004).

People living in bed and breakfast accommodation have high rates of some infections and skin conditions. Children also have high rates of accidents. Living in such conditions engenders stress in the parents and impairs normal child development through lack of space for safe play and exploration. Whilst cause and effect are hard to determine, at the very least homelessness prevents the resolution of associated health problems.

The total number of households placed in B&B/shared annexes in London fell during March 2005 to 3,323. The number of families with dependent children and/or a pregnant woman placed in this type of accommodation also fell to 241. However, 13 of these families had spent more than six weeks in B&B accommodation.

Map 15 Children as victims of crime, 2004/05**Map 16 Children as perpetrators of crime, 2004/05**

Map 14 (page 74) shows the number of families with dependent children in temporary accommodation by London borough in the last quarter of 2004. Six boroughs – Redbridge, Tower Hamlets, Enfield, Haringey and Brent north of the river, and Croydon to the south – had more than 2,000 families in temporary accommodation in the last quarter of 2004.

Indicator 5 – Crime

This indicator has been based on domestic burglary rates in earlier years, and these data can be found in earlier reports (see <http://www.londonhealth.gov.uk/hinl.htm>)

Children as victims of crime

While there is more emphasis on children and young people as perpetrators of crime, we need to remember that young people are also victims of crime. Southwark, Hammersmith and Fulham and Westminster rank highest for youth victims of crime, as Map 15 shows.

Under-16s are not interviewed in the annual government surveys that are combined with police statistics to provide a picture of crime and victimisation in the UK. This, combined with a tendency in many children not to report crime, makes it difficult to determine exactly how many are victims and the effect it has on them. It is fair to assume that children will have the same kinds of health effects including anxiety and sleep problems, following crime, as adults.

At a national level, the Mori *Youth Survey* (2004) suggests that young people in mainstream schools appear to be less worried about assault or theft, racism or bullying than in previous years, but worryingly, this is at the same time as the chance of being the victim of a crime seems to be going up (49% in 2004 against 46% in 2003) (MORI, 2004).

Children as perpetrators of crime

In this section, we draw on a report from the Government Office for London report on youth crime, which relies on Metropolitan Police 'accused' rather than 'offence' data on the grounds that since 'offence' data relies on witness or victim accounts, it may be less reliable on

indicators like age. In order to know whether a perpetrator is a youth (10-17 years) or an adult (18 years and over), this is particularly important (GOL, 2005). In 2004-5, young people accounted for 21% of the accused in London – the same as the previous year.

Map 16 shows the borough level figures for 2004-5. (These relate to the borough in which the crime was committed rather than where the perpetrators live). The boroughs with the greatest numbers of youth accused are Westminster, Bromley, Haringey, Croydon and Lewisham. However, the rate of youths accused per 1,000 population is highest in Westminster, Camden, Wandsworth and Hammersmith and Fulham. It is not possible to tell from 'offence' data whether or not this relates to imported crime, or crime by resident young people.

Data on the percentage change in the number of youths accused suggest that the largest increases between 2003/4 and 2004-5 were in Sutton, Camden, Brent and Hounslow. The largest decreases were in Hammersmith and Fulham and Newham where the number of youths accused fell by almost a quarter.

Indicator 6 – air quality indicators: NO₂ and PM₁₀

Air pollution levels depend on three factors – emissions, the weather and topography. In a 'bad-weather' year for pollution, concentrations in the air can increase while the sources of pollution have been reduced. This means that trends cannot easily be gauged from year to year, but should be considered over the longer term. *Health in London 2003* contains more detailed information, including modelled maps, from the Mayor's *Air Quality Strategy*, published in September 2002.

Air pollution can aggravate existing conditions, especially cardiovascular and respiratory diseases, and bring forward the deaths of vulnerable people. For example, PM₁₀ has an effect on asthma and NO₂ can set off allergenic responses. Ozone, the third problem pollutant for London, can worsen the symptoms of asthma and lung disease.

In general, the wealthier residents of London tend to live in the less polluted areas. However, there are many exceptions. For example, wealthy as well as poor people live along major roads, and outer London, which is relatively affluent, receives more ozone (GLA, 2002 Sept).

A government report in 1997 found a clear relationship between NO₂ and PM₁₀ levels and deprivation indices by ward (Pye 2001, quoted in The Mayor's *Air Quality Strategy*, GLA, 2002 Sept). This study concluded that policies focused on areas of high pollution could marginally reduce the apparent disadvantage of deprived communities in terms of air quality.

The more deprived residents are more likely to die of respiratory diseases, which

are linked to air pollution (*Environmental Health News*, 1999). However, there is as yet no direct evidence that the more deprived residents suffer poorer health or higher mortality through being exposed to higher concentrations. This is an area for further research.

Pollution is an important issue for children, and pollution and environmental issues are important to young people. Moreover, old people, young children and people with certain health problems are the most vulnerable to the effects of air pollution. For more details on this indicator, we refer readers to earlier *Health in London* reports (see www.londonhealth.gov.uk/hinl.htm) and summarise here some of the key issues.

The WHO has made reducing children's exposure to air pollution one of the four European regional priority goals – see <http://www.euro.who.int/child-healthenv/Risks/AirTop>

- In children, outdoor air pollution is associated with acute lower respiratory tract infections, asthma, low birth weight, and impaired lung function. The most significant health effects of outdoor air pollution are associated with particulate matter (PM).
- Provisional data already gathered for 2005 suggests that a main road in London is likely to exceed the EU objective for PM₁₀ causing the UK to be in breach of the EU directive on air pollution which aims to protect human health.

The August heat wave in 2003 resulted in the highest concentrations of ozone since 1990 and this has been associated with up to 800 excess deaths in England

and Wales. Furthermore a series of PM₁₀ episodes led to a widespread breach of the 2005 EU Limit value at roadside sites across London. The annual mean concentration index increased for all pollutants during 2003.

Indications for 2004 are that the daily mean PM₁₀ limit was exceeded at a number of sites throughout London but that the PM₁₀ incidents of 2003 were not repeated during 2004. The NO₂ annual mean objective continues to be breached but at fewer sites, representing an improvement on the situation reported for 2003. The ozone objective was also exceeded but mainly at sites in outer London.

Action on Air Pollution Update

In London, road transport emissions account for almost two thirds of the emissions of NO_x and more than half the emissions of PM₁₀ (GLA quoting LAEI figures for 2002). Traffic is also a major contributor to ground level ozone.

Transport related measures therefore form an important part, though by no means all, of London's *Air Quality Strategy* and recent developments include:

- The launch in December 2004 of the Mayor's *Taxi Emissions Strategy* which will reduce the emissions from London's taxis, by up to 50% by the end of 2007.
- Taxis are responsible for 24% of fine particle and 12% of nitrogen oxide of road transport emissions in central London. London's 20,000 black taxi fleet will be expected to meet strict emissions standards by 2007, under the Mayor's *Taxi Emissions Strategy*. Taxi owners and operators will be able to use innovative technology, as

Table 13 Fatal and serious casualties among children aged under 16 in London in 2004 (all roads)

		Casualty numbers		% change in 2004 over	
	1994-1998 average	2003	2004	2003	1994-1998 average
Child pedestrians	591.6	324	304	-6%	-49%
Child pedal cyclists	110.6	62	47	-24%	-58%
Child car passengers	195	109	89	-18%	-54%
Child bus/coach passengers	20.8	16	21	-31%	1%
Other child casualties	17.4	32	26	-19%	49%
All child casualties (under 16)	935.4	543	487	-10%	-48%

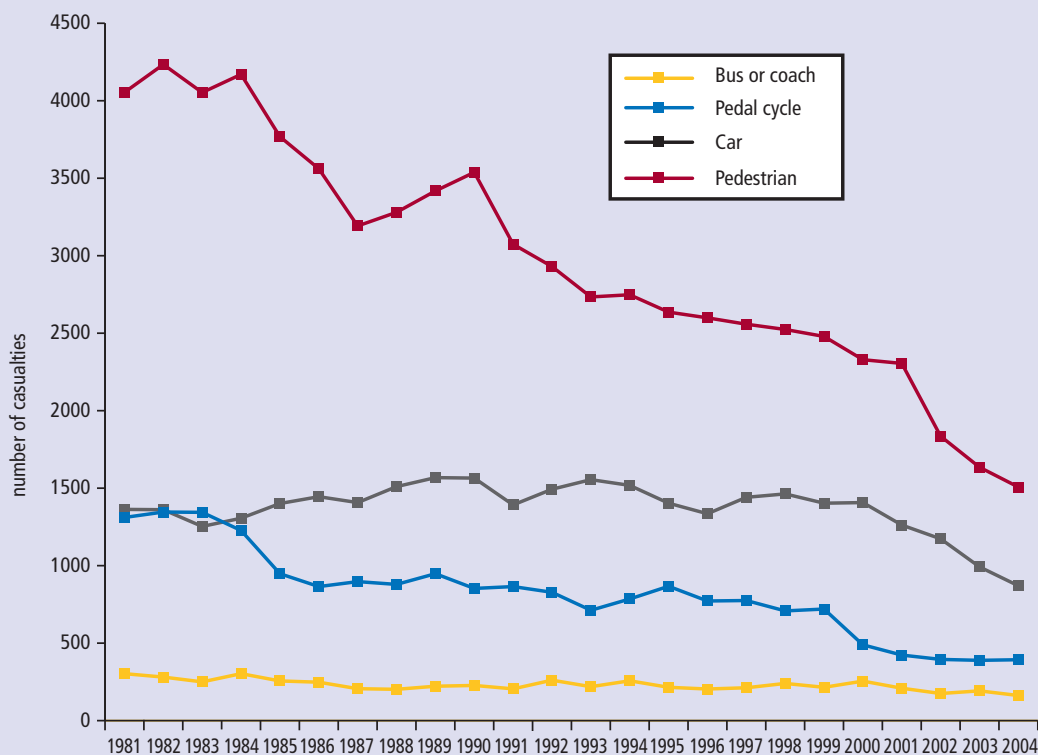
Source: LAAU

Table 14 Child casualties in London, rates per 1,000 population, 2004

	No	All 0-17 rate	0-4 rate	5-9 rate	10-15 rate	16 rate	17 rate
Inner London	1,556	2.6	0.9	2.2	3.6	5.2	6.3
Outer London	2,648	2.6	1.0	1.8	3.2	6.6	7.6
Greater London	4,204	2.6	1.0	1.9	3.3	6.1	7.1

Source: GAL estimates based on figures from LAAU and ONS 2003 mid-year population estimates

accredited by the Public Carriage Office and Energy Savings Trust, to reduce their emissions. Funding for these options will be provided through a small environmental surcharge on each fare, from April 2005.

Figure 17 Child road casualties in London by mode of travel, 1981-2004

Source: London Accident Analysis Unit, Transport for London

Indicator 7 – Road traffic accidents

Unintentional injury in childhood is an important cause of death and disability, and one where there are big differences between the 'best-off' and 'worst-off' children.

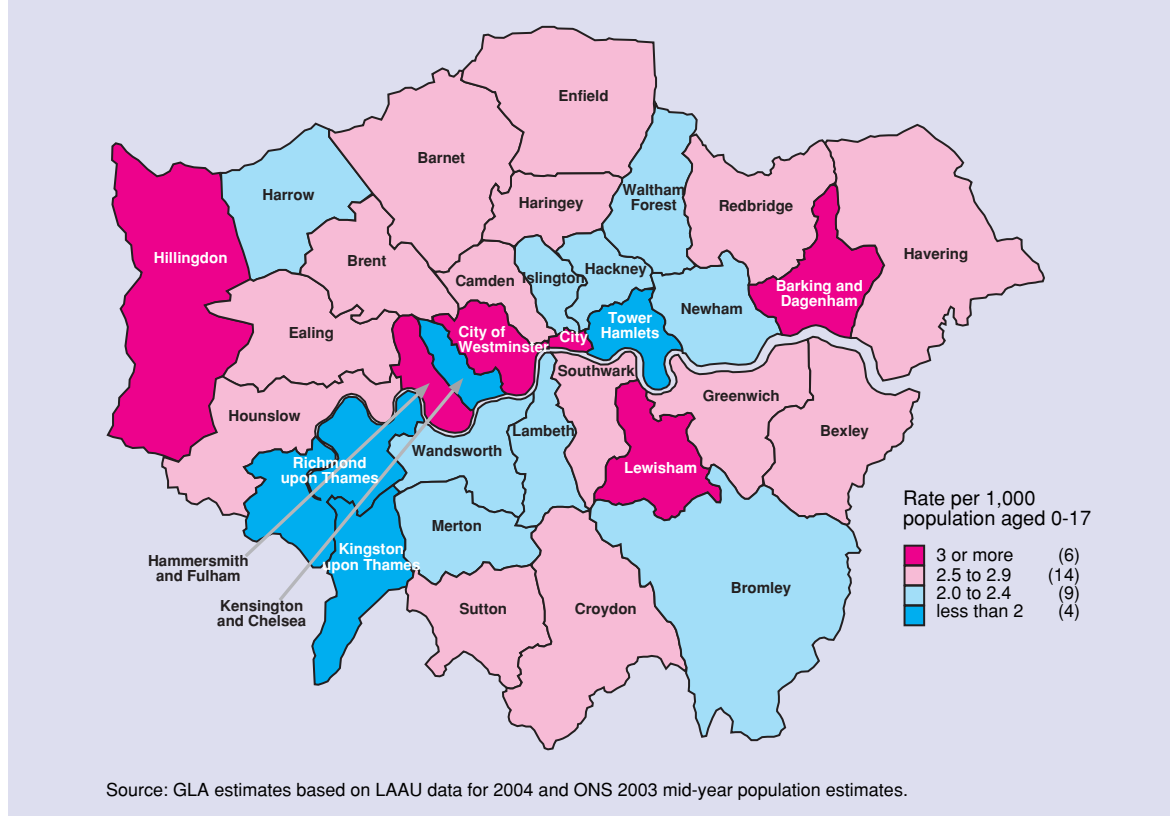
Key Findings

- Following a rapid decrease in the number of child casualties in London in the early 1990s, the casualty figure remained at about the same level between 1993 and 1998 to be followed by further decreases up to 2004.
- Casualty rates have fallen for both walking and cycling, but less noticeably for child passengers in vehicles.
- 20mph zones are an effective way of reducing the frequency and severity of accidental injury, mainly through reducing traffic speed.

Child road casualties in London

The Government casualty reduction targets for 2010 includes a 50% reduction in the number of children killed or seriously injured (KSI) in road accidents (Department of Transport, 2004). Table 13 shows that, following a decrease of 10% in 2004 over the previous year, child road casualties in London were close to the 2010 national target at 48% below the 1994-98 average (London Accident Analysis Unit (TfL), 2005). Child road casualties by the various modes of travel were all at least at this level of decrease with the exception of child bus/coach passengers, where the KSI figure had increased by 1% over the 1994-98 average.

In 2004, there were 4,200 child casualties on London's roads corresponding to a rate of 2.6 per 1,000 population aged 0-17. This compares with a rate for Great Britain as a whole of 3.6 per 1,000. While the majority of casualties occurred in outer London boroughs, the inner and outer London

Map 17 Child casualties in 2004 (all modes)

rates were the same. As one might expect, casualty rates increase with age. The casualty rate among 17 year olds, for example, is more than three times the rate for 5-9 year olds (Table 14).

Figure 15 shows child casualties aged 0-15, by mode of travel, between 1981 and 2004. Child pedestrian casualties have dropped significantly over this period from over 4,000 to around 1,500. There has been a reduction in car passenger casualties from a peak of over 1,500 in the early 1990s to 870 in 2004. Pedal cycle casualties have also fallen significantly over this period and now stand at less than a third of the figure for the 1981 base year.

One reason why child casualties in Britain have fallen is the shift to car use. However, low-income households do not have this option (Hewson, 2002).

Map 17 shows the road casualty rates among children in 2004 at London

borough level. In terms of casualties per 1,000 population aged 0-17, rates ranged from 3.7 in Lewisham to 1.4 in Kensington and Chelsea (the City is excluded due to the small numbers involved). Westminster, Hammersmith and Fulham, Hillingdon and Barking and Dagenham also have high rates, although there does not appear to be a distinct spatial pattern to child road casualties in London.

Note that many casualties do not involve local residents but people from outside, especially in central London; this affects adult commuters most of all, but children as well.

20 mph zones

In 2002, the London Road Safety Unit commissioned a review of the effectiveness of 20 mph zones in London (TfL, 2003). The zones studied have almost exclusively been implemented on unclassified roads that previously had a 30 mph limit and, prior

to the introduction of the 20 mph zone, had twice as many accidents per km per year as other unclassified roads. The research showed that 20 mph zones are an effective way of reducing the frequency and severity of injury accidents, mainly through reducing traffic speeds.

Data provided by the London boroughs shows the number of 20 mph zones being installed annually has increased from about five per year prior to 1999 to over 30 per year by 2002, with a total of about 137 zones installed by 2002. The introduction of 20 mph zones in London has had a significant impact on child injuries, reducing the KSI casualty frequency for children by 60 per cent.

Social class

Research in various countries shows that the child pedestrian casualty rate is typically four times as high in the lowest socio-economic group, when compared to the highest (DETR 2001). Risk factors affecting poor families include overcrowding; high housing density; lack of safe garden space and communal playing areas; children walking to school, especially unaccompanied or with other children; unsympathetic road design and lack of safe spaces to cross; volume and speed of traffic. Social and psychological factors are also thought to play a part.

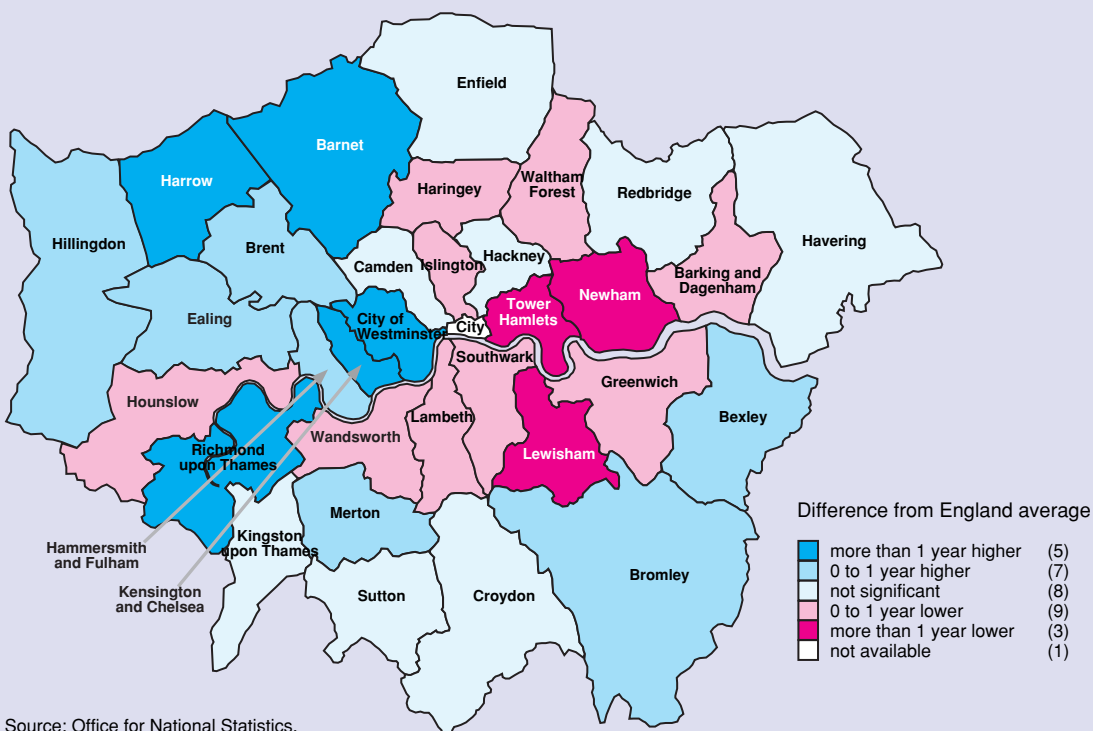
Although poor people tend to live in higher-risk areas, modern planning can do much to design out the risk.

Indicator 8 – Life expectancy at birth

Life expectancy at birth for an area is an estimate of the average number of years a new-born baby would survive if he or she experienced the particular area's age-specific mortality rates for that time period throughout his or her life. The figure reflects mortality among those living in the area in each time period, rather than mortality among those born in each area. It is not therefore the number of years a baby born in the area in each time period could actually expect to live, both because the death rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

Life expectancy at birth is also not a guide to the remaining expectancy of life at any given age. For example, if female life expectancy was 80 years for a particular area, life expectancy of women aged 75 years in that area would exceed five years. This reflects the fact that survival from a particular age depends only on the mortality rates beyond that age, whereas survival from birth is based on mortality rates at every age.

Average life expectancy is determined by mortality at all ages. Therefore, the range of influences on life expectancy is vast and includes all those influences on health at each age. All of the health determinants will have an impact on life expectancy. Average life expectancy is therefore a good summary indicator of the health status of the population. A gap in health status exists between different areas in the country, different social groups, the population as a whole, different black and minority ethnic groups, and men and women.

Map 18 Life expectancy, males, 2001-03**Map 19** Life expectancy, females, 2001-03

Key findings

- Life expectancy in London in 2001-03 was 76.0 for males and 80.8 for females. This is similar to the life expectancy for England as a whole which was 76.2 for males and 80.7 for females.
- In 2000-2002 life expectancy in London was 75.8 for males and 80.8 for females. There does not appear to have been a change in life expectancy between 2000-02 and 2001-03.
- Five boroughs had a life expectancy that was at least one year higher than England for males. These were Barnet, Harrow, Kensington and Chelsea, Richmond and Bromley.

Barking and Dagenham, Greenwich, Hackney, Haringey, Islington, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets and Waltham Forest (Map 18).

For females, Lewisham, Newham and Tower Hamlets had a life expectancy that was more than a year lower than England in 2001-03. Five boroughs had a life expectancy that was at least one year higher than England for females. These were Westminster, Barnet, Harrow, Kensington & Chelsea, and Richmond (Map 19).

Life expectancy at birth

The Department of Health 2004 PSA targets include increasing average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women, and to reduce health inequalities by 10% by 2010 as measured by life expectancy at birth (PSA priority 1).

There are wide variations in life expectancy by ward in London. Most of the wards with significantly low male and female life expectancy are in inner London. However, there are pockets of areas in more prosperous outer London with low life expectancy. Previous *Health in London* reports have shown that borough level average life expectancy is closely related to the level of deprivation, with a stronger association between life expectancy and deprivation for males than for females.

For males, many boroughs had a life expectancy that was at least a year lower than England in 2001-03. These were

Indicator 9 – Infant mortality rate

The infant mortality rate has long been used as a general indicator of the health of the population. Factors such as ethnicity, socio-economic circumstances, parental behaviour and poor health care are all potential risk factors for infant death. Higher than average infant mortality rates have been found in babies whose mother's were born outside England and Wales, young mothers, babies whose fathers were in the routine and manual social class, babies born with a low birthweight, babies that were registered by the mother alone and babies born in deprived areas. Differences in the prevalence of risk factors by geographic area results in geographic variations in infant mortality rates.

Poor babies are more likely to be small, premature or both (MacFarlane and Mugford, 2000). They are also less likely to be breastfed.

Key issues

- The infant mortality rate for London was 5.7 deaths per 1,000 live births in 2001-2003. The rate was significantly higher than London in Southwark, Hackney, Brent, Haringey and Newham, and significantly lower than London in Kingston, Wandsworth, Barnet and Bromley.
- The stillbirth rate for London was 6.4 stillbirths per 1,000 total births in 2001-2003. The rate was significantly higher than London in Newham, Greenwich and Lewisham, and significantly lower in Wandsworth, Havering, Bromley and Sutton.
- The perinatal mortality rate for London was 9.2 per 1,000 total births

in 2001-03. Newham, Lambeth, Greenwich and Lewisham had rates that are significantly higher than London. Wandsworth, Havering, Bromley and Sutton had rates that were significantly lower.

- The neonatal mortality rate for London was 3.9 per 1,000 live births in 2001-03. Southwark and Lambeth had significantly higher rates and Wandsworth and Havering had significantly lower rates than London.

Influences on infant mortality

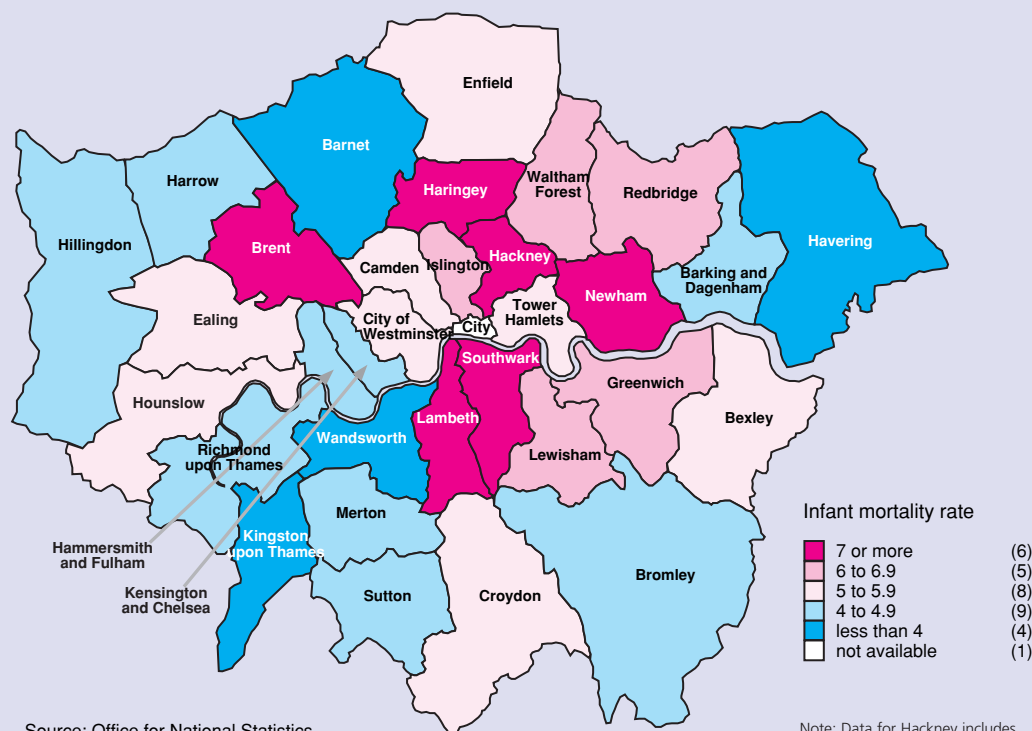
Whilst there have been huge improvements in important measures of child health in the UK over the last century, the UK is still rather poorly placed in the world league table of infant mortality. Figures available for a range of OECD countries for 2001, show the UK as having an infant mortality rate of 5.5 per 1000 live births, higher than that of most other European countries, and considerably higher than those for Iceland, Finland, Sweden, Norway, Spain, Czech Republic, Italy, Germany, France, Austria and Denmark (OECD, 2003).

Research by Richardus et al (2003) helps to shed some light on some of the factors associated with these differences. Their audit, investigating associations between perinatal mortality rates and characteristics of care across 10 European countries, found a positive association between the proportion of cases with care that was rated as less than optimal and overall mortality rates. The most common areas of less than optimal care were failure to detect intrauterine growth restriction and maternal smoking. Another international study of 19 wealthy OECD countries by Macinko et al (2004) found that the level of wage inequality for a country was significantly associated with infant mortality rates.

The definitions below relate to the maps which follow:

Stillbirth rate	Stillbirths (after 24 weeks) per 1000 total births (live + stillbirths)
Perinatal rate	Stillbirths plus deaths to babies under 7 days per 1,000 total births
Neonatal rate	Deaths to babies under 28 days per 1,000 live births
Post neonatal rate	Deaths to babies aged 28 days and over and less than one year per 1,000 live births
Infant rate	Deaths to children under 1 year per 1,000 live births

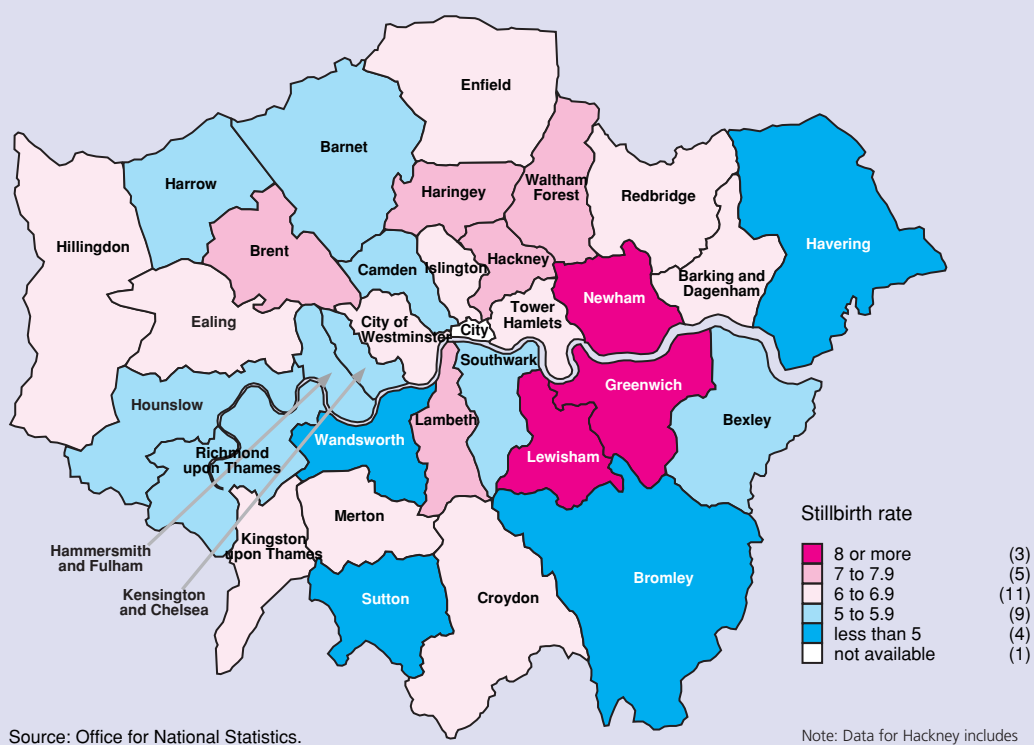
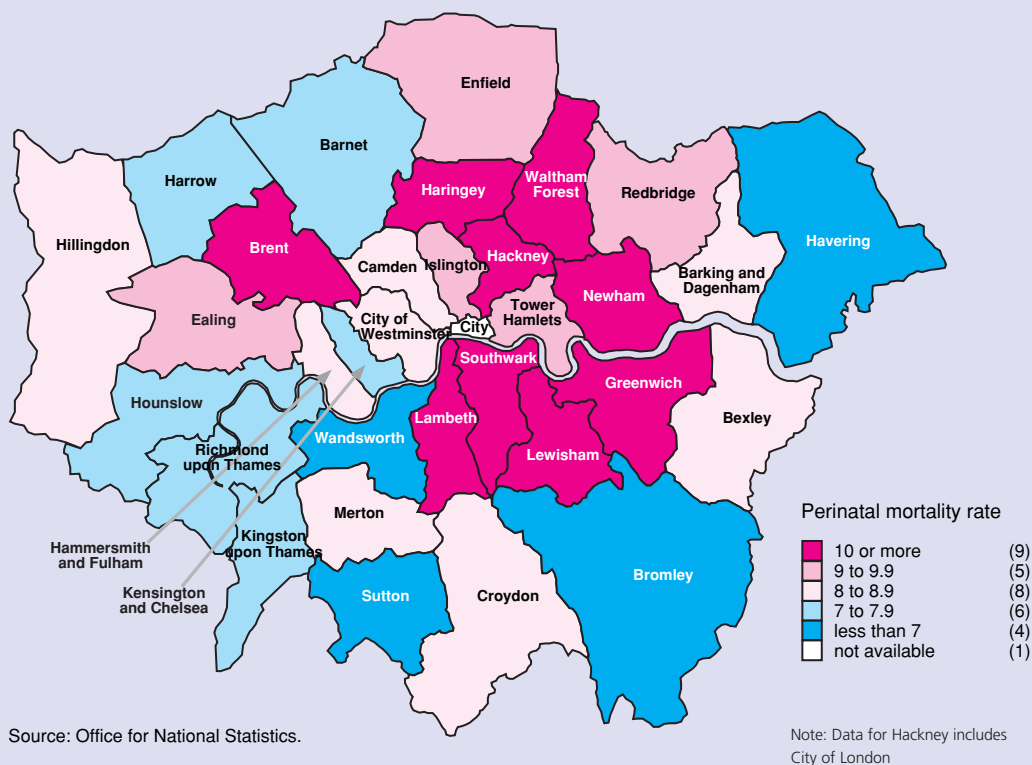
Map 20 Infant mortality rate per 1,000 live births, 2001-03

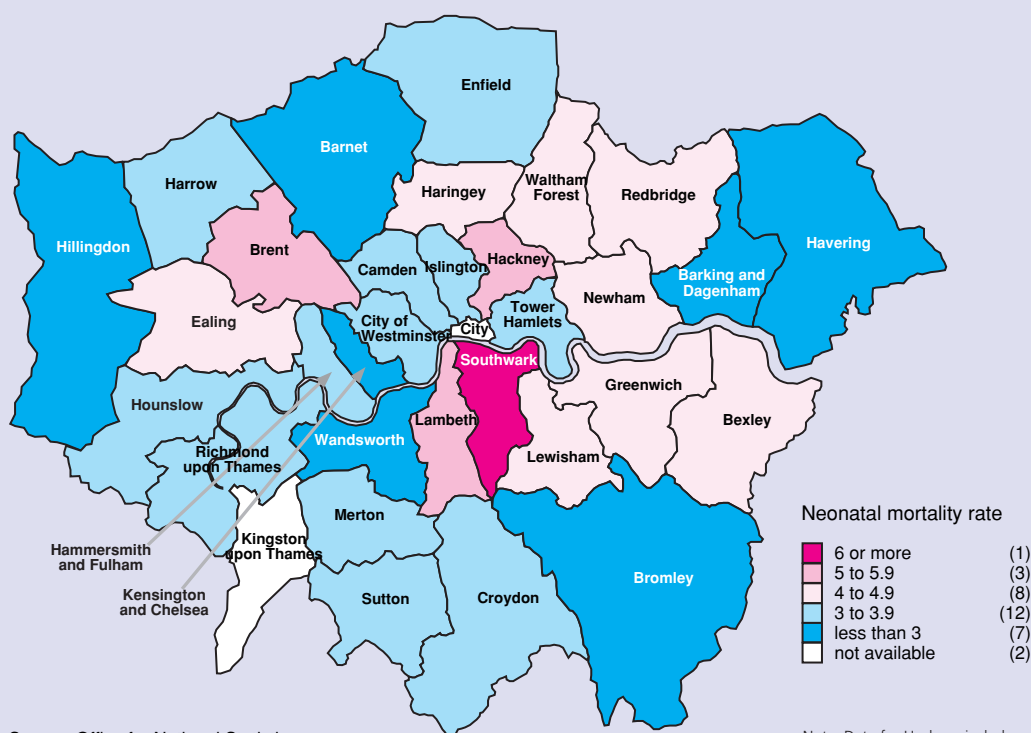


Source: Office for National Statistics.

The pattern of causes for infant and child mortality has remained much the same over the past decade. The main causes of death among infants (under one year) are conditions related to immaturity, followed by congenital anomalies. Sudden infant deaths (SID) have continued to decline, though in England and Wales SID rates are higher for babies born to mothers under 20 and mothers born outside the UK. A review carried out by Ponsonby et al (2002) found that the rate of decline in SID was slower for different ethnic and socio-economic groups.

The national health inequalities target on infant mortality aims for a reduction in the gap between the infant mortality rate in the routine and manual classes and the population as a whole. This target is difficult to monitor at local level as the number of infant deaths in any given local authority or Primary Care Trust (PCT) among a particular social class group is very small and subject to random fluctuations from year to year. In addition, social class is only coded for 10% of live births every year.

Map 21 Stillbirth rate per 1000 births, 2001-03**Map 22 Perinatal mortality rate per 1000 births, 2001-03**

Map 23 Neonatal mortality rate per 1000 live births, 2001-03

Nevertheless, there are wide inequalities in infant mortality rates by local authority in England and monitoring these inequalities is essential to understanding trends in inequalities in infant mortality.

Maps 20 – 23 indicate the ways in which patterns of early death follow much the same patterns relating to deprivation seen for other indicators.

A major cause of infant mortality is being born too small – low birthweight. Low birthweight is defined by the World Health Organization as a birthweight less than 2,500 grams. Low birthweight infants account for approximately 7% of all live births in England and Wales. In

addition, low birth weight is also associated with health problems in adulthood such as neuro-cognitive and pulmonary morbidity and other long-term health difficulties including deficits in growth, cognitive development, diabetes and heart disease.

Low birthweight is a well-established risk factor for immediate and long-term health problems. An analysis of ONS birth weight statistics for England and Wales by Macfarlane et al (2004) found a range of associated factors including father's occupation (the proportion of low birthweight babies born to fathers in manual occupations was higher than to fathers in non-manual occupations),

ethnicity (the mean birthweight of babies born to Black and Asian mothers was lower than those born to white mothers) and age (teenage mothers and mothers over 40 more likely to have low birthweight babies).

Low birthweight varies widely according to socio-economic status. Macfarlane and colleagues, looking at births in England and Wales between 1991 and 1995, found that the percentage of low birthweight births was 5.4% in social class I (based on the occupation of the father), compared with 8.2% in social class V.

Indicator 10 – Proportion of people with self-assessed good health

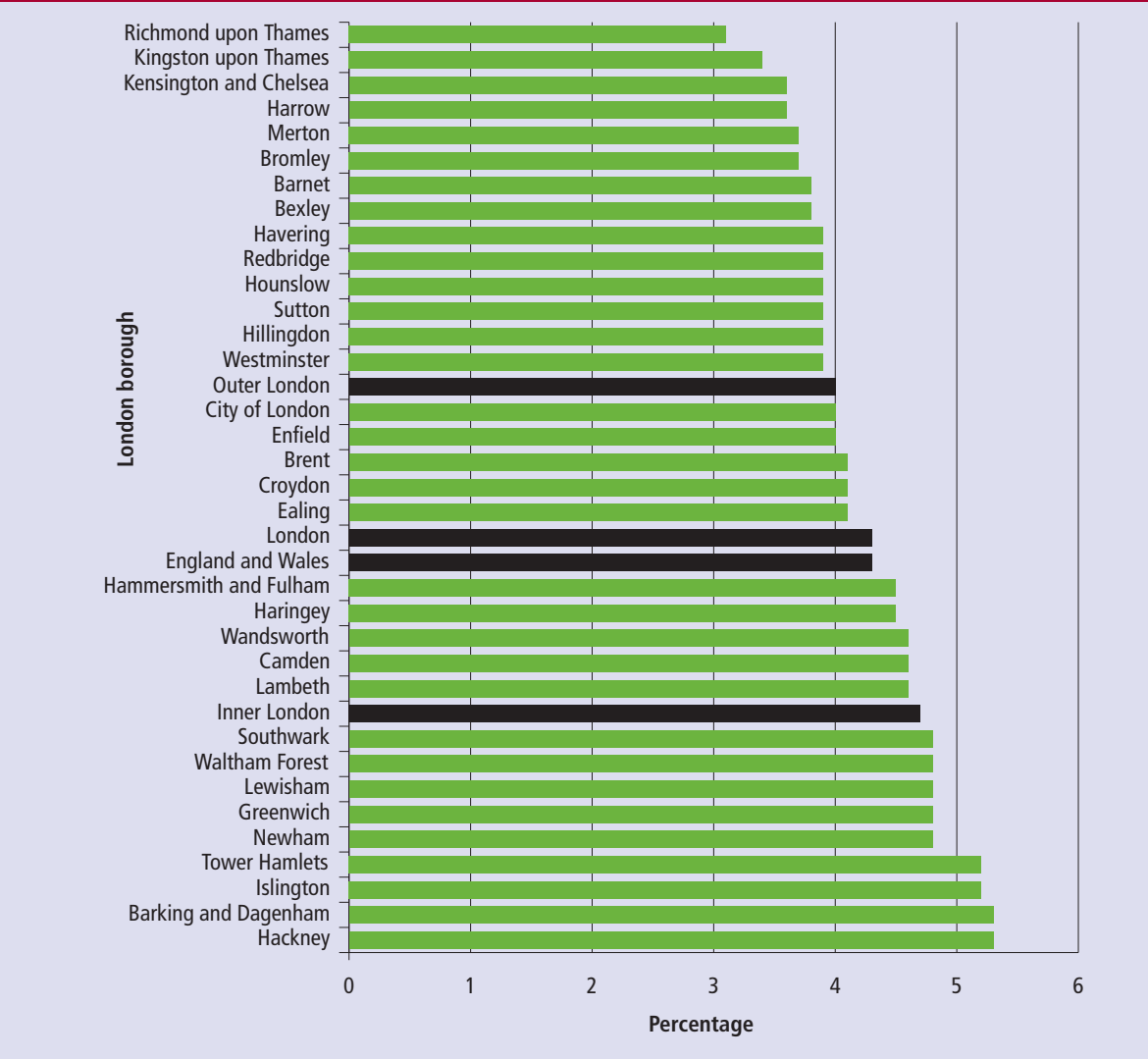
This indicator shows the percentage of people in the age groups specified reporting good health. The 2001 Census question asked respondents to assess their own personal health as “good”, “fairly good” or “not good”. The instructions for that part of the Census form were that they were to be filled in by each member of the household (with those aged 16 or over eligible to ask for their own form if they wished, for privacy reasons). We do not have data on how many children and young people

did in fact complete this question themselves.

This year, we have concentrated on self-assessed health of children and young people drawing on Census data supplemented by data from other surveys although these may ask a slightly different question.

There have been some questions about the reliability of self-assessed health, and what people mean by this. Meltzer (2003) describes how respondents to the 1984 *Health and Lifestyles Survey*, for example, were asked what they understood by the term ‘health’: among the aspects which they mentioned were

Figure 16 Percentage of dependent children with a limiting long-term illness, London 2001



Source: 2001 Census, Theme Table TT01

absence of disease, functional ability, and fitness (both physical fitness and psychological well-being). Also identified were a 'moral' dimension, whereby health depended on will-power, self-discipline and self-control; health as healthy behaviour (being a non-smoker or non-drinker, taking exercise); and health as a 'reserve' which could be diminished by neglect and accumulated by good behaviour (Blaxter, 1990).

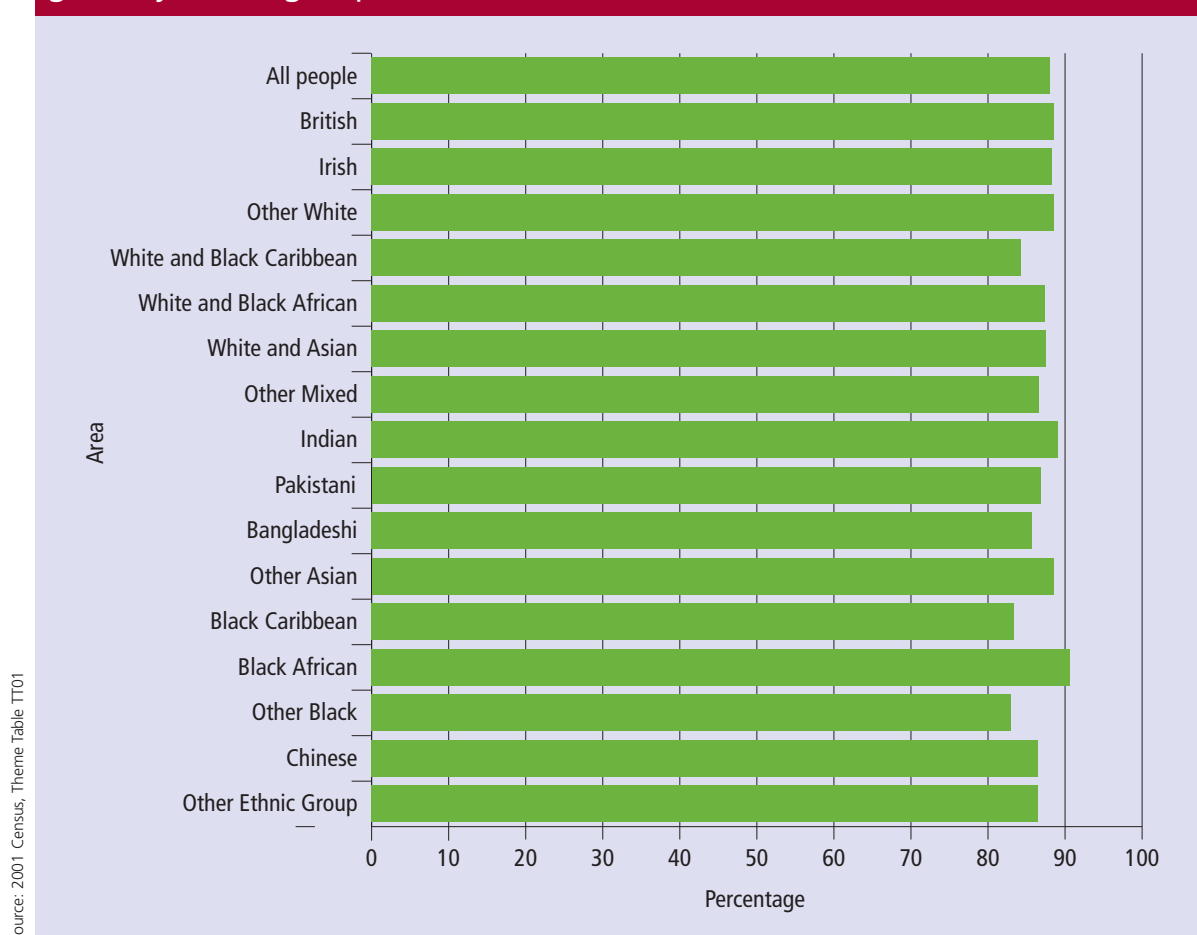
Participants in the 2001 Census question-testing programme also referred to frequency of doctor consultations, whether or not people were absent from school or work because of ill-health, and whether or not they were taking medication. People in different population groups also emphasise different dimensions in

their definitions of health; functional ability is more likely to be mentioned by older people, and fitness by younger people.

Key Findings

- For those aged between 10-14 years, the proportion reporting good health in England was 91.5%. In London the average was slightly lower at 90.0%.
- At borough level, for those aged between 10-14 years, the proportions reporting good health range from 86% to 96%.
- For those aged between 15-19 years, the proportion reporting good health in England was 86.8%. In London the average was slightly higher at 86.3%.

Figure 17 Percentage of population aged 10-19 reporting their health as good by ethnic group, London 2001



- The range reporting good health amongst 15-19 year olds at London borough level was 83%-90%.
- The proportion reporting good or very good health was relatively low in manual social classes, and for both boys and girls in families with low incomes.
- Black African young people were the most positive about their health, followed by Indian young people. Those reporting less positively on their health were those identifying as Black Caribbean or Black Other.

slightly lower (young men 87%, young women 84%). Ratings of health initially improved with age to about age nine, then declined.

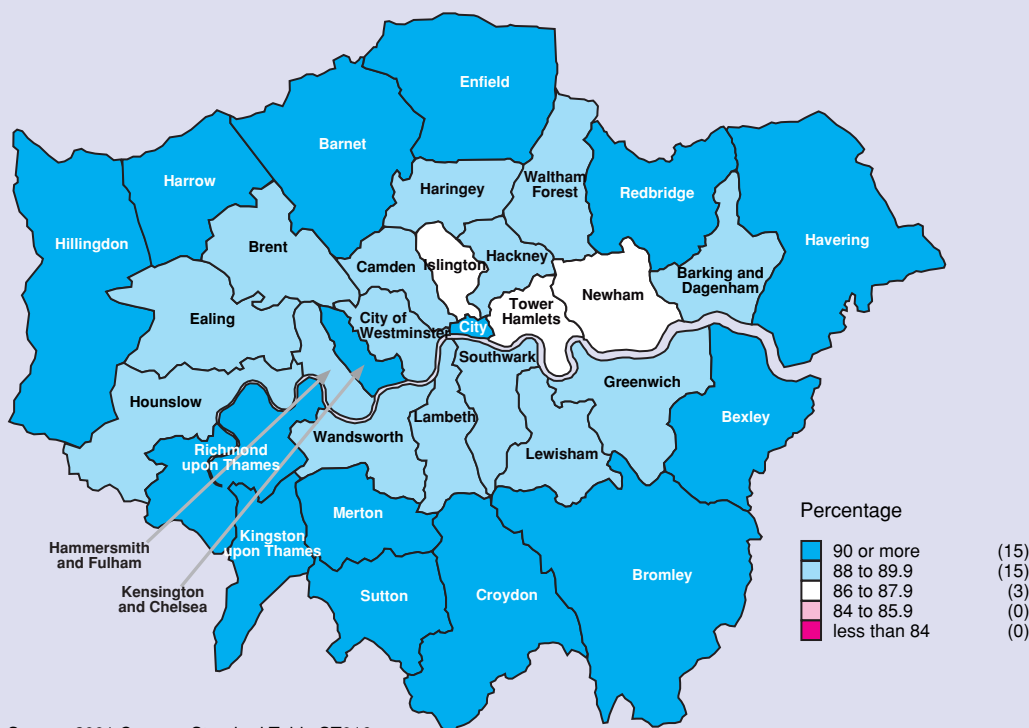
The proportion reporting good or very good health was relatively low in manual social classes, and for boys and girls in households with lower incomes. Self-reported illness on the other hand did not present quite such a positive picture in the same survey, with just over a quarter of boys and just under a quarter of girls aged 2-15 years reporting a longstanding illness, with 10% indicating that it limited their activities in some way.

Young people's self-assessed health

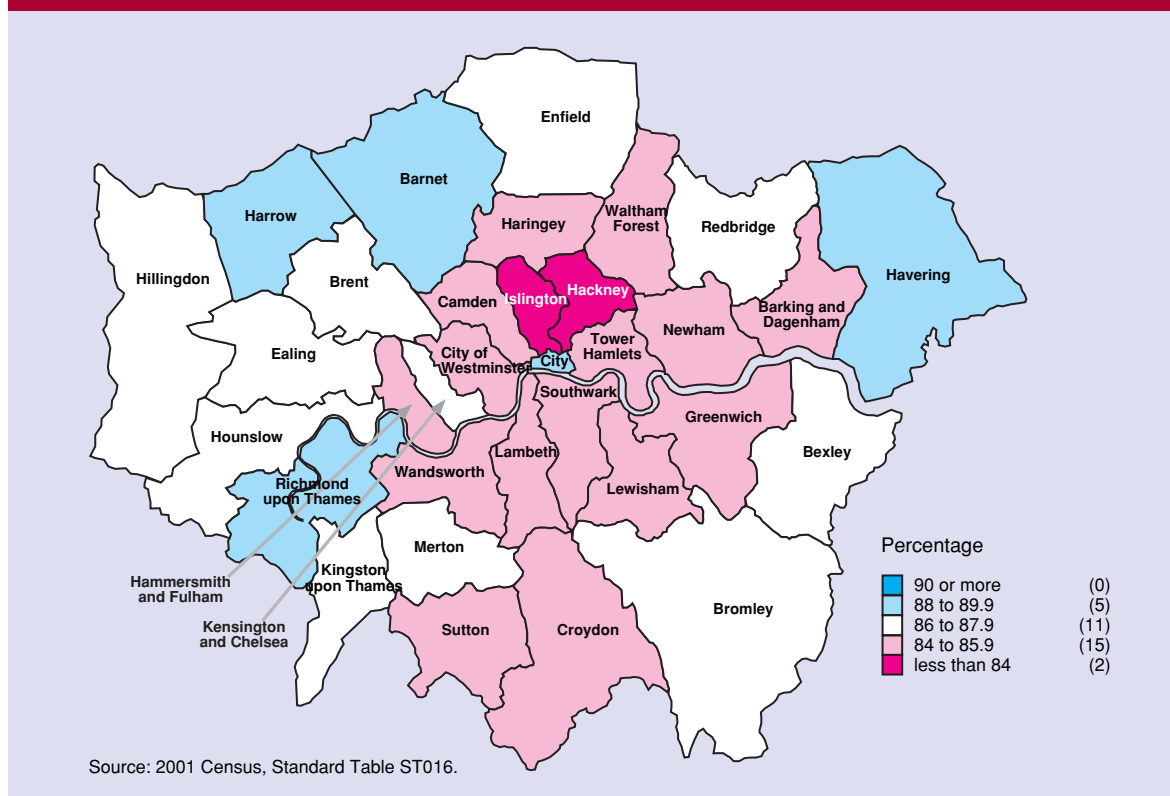
In the *Health Survey for England* (1995-97) the health of about nine in ten boys and girls was rated (by themselves if aged 13 or over, by their parents if aged 2-12) as 'good' or 'very good' (91%). Among young adults, proportions were

The data from the 2001 Census (Figure 16) shows the differences between the 'best-off' and 'worst-off' areas in terms of limiting long-term illnesses in dependent children, demonstrating that inner London is worse off than outer London in this respect. In general,

Map 24 Percentage of the population who report their health as good, 10-14 year olds



Map 25 Percentage of the population who report their health as good, 15-19 year olds



however, London has the same average rates of limiting long-term illness in dependent children as England and Wales.

Map 24 shows stark differences between inner and outer London. More than 90% of those in outer London assessed their health as good, while in inner London, children and young people are less positive. Map 25 indicates young people aged 15-19 assessing their health less favourably than the 10-14 year olds.

Finally, Figure 17 suggests that Black African young people were most positive about their health, followed by Indian young people. Those reporting less positively on their health are those identifying as Black Caribbeans or Black Other.

Overall findings and implications and opportunities for action



In this section...

Overall findings:

- Summary of key findings from the 10 high-level indicators
- How London is different from the rest of England
- Inequalities within London – geographical and by population groups

Implications and opportunities for action:

- Implications for strategic and partnership work
- Additional opportunities for change within different types of service/interventions

Introduction

As London boroughs prepare for the changes envisaged in *Every Child Matters* and develop greater integration through *Children's Trust* arrangements, it is imperative that we focus on planning and investing in actions which will help reduce the health inequalities experienced by London's children. New national policies present an important opportunity for organisations to work together in more co-ordinated ways to improve health outcomes. This requires investment in action to improve the determinants of health and not taking too narrow a 'lifestyle' approach.

A basis for both this report and for *Every Child Matters* is the need for good evidence to underpin policy and practice. It is worth remembering that children are experts in their own lives, and that the ECM documentation views the genuine participation of children, young people, parents, carers and families as crucially important.

Inequalities in health expose unacceptable levels of difference in life chances for children and young people living in the UK, and differences even for those living within the same city. However, the very existence of differences between boroughs and groups is evidence that things do not have to remain the way they are. We need to investigate further the key success factors in areas where good progress is being made relative to other areas so that we can implement 'what works' more widely. Sharing information on effective or promising practice is important. We also need to maximise the opportunity to use Health Impact Assessment of wider policies at local levels to include a focus on young people's health and health inequalities.

Inequalities in health develop insidiously, and need time to be put right. Not all of the indicators in this report are susceptible to fast change. However, there is some cause for optimism. Naming and identifying problems is the first step to solving them. We need to tackle the causes of avoidable ill health at root. That entails a focus on poverty, deprivation and action to improve the wider determinants of health for children.

Intervening in childhood and adolescence can save lives and close the health gap. Moreover, so long as interventions to reduce inequalities are well designed and well delivered, they can provide benefits in the here and now for children and parents, as well as promoting change later.

Key findings

Key findings from the 10 high-level indicators

Unemployment – indicator 1

Over 40% of all children in London and over half of children in inner London are living in poverty. Child poverty is strongly associated with being in a household without an adult in employment.

Unemployment and ethnicity – indicator 2

Overall in London, a third of Black and Minority Ethnic children live in households without an adult in employment. However, there are significant differences within London. For example, only 11% of Indian children live in 'workless' households, compared with 20% of white children.

Educational attainment – indicator 3

Generally, children are not performing as well in London at GCSE level as they are nationally, although this masks variations across London. In terms of the Key Stages, while Key Stage 1 results are less

good overall than national rates, performance at Key Stages 2 and 3 are improving. Even so, the results for inner London are 10% below the nationally expected levels.

Housing – indicator 4

England's ten worst local authority areas for overcrowding are all in London, and some minority ethnic groups are at particular risk for overcrowding. Children and families living in temporary accommodation are at risk of a whole range of health problems, including unintentional injury.

Crime – indicator 5

Southwark, Westminster, and Hammersmith and Fulham have the highest rates of youth victims of crime. In 2004-5, young people accounted for 21% of the accused in London – the same as the previous year. The boroughs with the greatest numbers of youth accused are Westminster, Bromley, Haringey, Croydon and Lewisham.

Air Quality – indicator 6

Indications for 2004 are that the daily mean PM₁₀ limit was exceeded at a number of sites throughout London. The NO₂ annual mean objective continues to be breached, but at fewer sites than in 2003. The ozone objective was also exceeded, but mainly at sites in outer London.

Road Traffic Accidents – indicator 7

In 2004, there were 4,200 child casualties on London's roads, although there have been decreases since the early 1990s.

Life expectancy at birth – indicator 8

Life expectancy in London in 2001-3 was 76 years for men and 81 for women, which is similar to England as a whole. Life expectancy is closely related to deprivation and there are

differences between London boroughs; more deprived boroughs had a shorter life expectancy than less deprived boroughs.

Infant mortality – indicator 9

The infant mortality rate for London was 5.7 per 1,000 births in 2001-3. The rate was higher in Southwark, Hackney, Brent, Haringey and Newham and lower in Kingston, Wandsworth, Barnet and Bromley. A major cause of infant mortality is being born too small or too early.

Self assessed good health – indicator 10

The percentage of those aged 10-14 reporting good health was similar in London (90%) to England as a whole (91%). The percentage of those reporting good health drops as young people get older, in both London and in England as a whole. There are differences between inner and outer London, with young people in inner London less positive about their health.

Overall findings

How London is different

When taken as a whole, London's performance is **similar to or better than** the rest of England on the following indicators:

- in London the proportion of people aged 15-19 who reported their health as good was similar to but slightly higher than the proportion in England (83.6% compared to 82.3%)
- for the younger age group (10-14 years), the proportion reporting good health in London was similar to but slightly lower than the proportion nationally (89.8% compared to 90.7%)

- life expectancy in London is similar to life expectancy for England as a whole
 - the infant mortality rate in London (5.7 deaths per 1,000 live births) is similar to the UK rate of 5.5 per 1,000; but this is higher than most other European countries
 - GCSE performance is similar to the national average, with 53% of children achieving five or more GCSEs with A* to C grades compared to 54% nationally
 - around 84% of people aged 18-24 are in employment or full-time education in London, which is just above the national average (although London has the lowest proportion of people in employment compared to those in education)
 - in 2004, child casualty rates on London's roads were lower than the rate for Britain as a whole – 2.6 casualties per 1,000 people under 17 years, compared with the national rate of 3.6 per 1,000
 - children and young people in London had the highest fruit and vegetable consumption of any English region in 2002
 - children aged 5-10 years have similar levels of mental health problems to children elsewhere in the country
 - young Londoners report lower levels of alcohol consumption than young people in other regions and are considerably more likely to report that they never drink.
 - London's workless households with dependent children accounted for one in five of all such households in England, with inner London having higher rates than any English region
 - about 24% of dependent children in London live in households where no adults are in employment, compared with 18% nationally
 - educational attainment in London at Key Stage 1 is lower than elsewhere in England with performance below the national average on reading, writing and mathematics
 - 28.5% of all dependent children in London were living in overcrowded conditions in 2001 compared with the England and Wales average of 12.3% – all ten of England's worst local authority areas for overcrowding are in London
 - teenage pregnancy rates are higher in London and, unlike elsewhere in England and Wales, do not show a reducing trend
 - in 2003, conception rates for girls under 18 years were 21% higher in London than England, and London had the highest conception rate for girls under 16 years
 - diagnoses of sexually transmitted infections continue to rise, and gonorrhoea rates in London were approximately double the England rate in 2003
 - overall rates of mental disorder among children aged 5-15 years are higher in inner London than elsewhere in the UK, and were particularly high for boys aged 11-15 years
- When taken as a whole, London's performance is **worse than the rest of England** on the following indicators:

- rates of illicit drug use in London remain consistently higher than in other regions in England and Wales.

Inequalities within London

Geographical variations

Looking at London's overall performance on health helps with identifying some issues, but masks the considerable variation that occurs within the capital in terms of both health determinants and health outcomes. Borough-level data and, where available, ward-level data, are presented in Sections 3 and 4 of this report and some of the differences between areas are summarised below. In particular, this highlights an ongoing divide between inner London and outer London on many issues.

- The proportion of young people in London reporting that their health is good varies between boroughs. For 10 to 14 year olds, the proportion ranged from 83% to 93%, and for 15 -19 year olds the proportion ranged more widely from 71% to 89%.
- There are wide inequalities in life expectancy within London. At borough level, average life expectancy is closely related to levels of deprivation, which is a feature of many areas in inner London. However, previous reports have shown that there are also pockets in more prosperous outer London with low life expectancy.
- Infant mortality rates continue to vary between London boroughs and low birthweight (a major cause of infant mortality) is more than twice as high in some London boroughs than others.
- The proportion of young people who are not in full time education or employment varies widely across London boroughs (from 7.4% to 32.7%), with outer London boroughs tending to have better performance in this area
- There are large differences in children's risks of being in a workless household, with inner London children at far greater risk in most cases than those in outer London
- The proportions of 15 year old children achieving five or more GCSEs at grades A* to C range from 40% to 68% across London boroughs. Key Stage 3 performance was close to the national averages for English, mathematics and science in outer London, but inner London results are around 10 percentage points below national levels
- The proportions of children living in overcrowded housing are significantly higher in inner London than in outer London
- Emergency hospital admissions for children under one year old are highest in Hackney and lowest in Havering. For those aged between one and nineteen years, emergency admission rates are highest in Hackney, as before, and lowest in Kensington and Chelsea
- Teenage conception rates in London boroughs range from the lowest in England – found in the boroughs of Richmond and Harrow – to the highest which is found in Lambeth. Teenage conception rates vary both between and within boroughs, and are clearly related to deprivation
- There is currently a lack of borough-level data on several health issues, including childhood obesity, which is linked to both short- and long-term health problems.

London's BME communities

The 2004 *Health in London* report had a specific focus on the health of London's Black and Minority Ethnic communities. Much of the information in last year's report is still current and many of its conclusions remain relevant. The full report can be found at <http://www.londonhealth.gov.uk/hinl2004.htm>

The findings below are summarised from elsewhere in this report and supplemented by a few from last year's report. They highlight the ongoing existence of inequalities between communities' access to health determinants and continued differences in communities' experience of health issues.

- In London in 2001, Black African young people were the most positive about their health, followed by Indian young people. Those reporting less positively on their health were young people who identified as Black Caribbean or Black Other.
- Maternal and neonatal outcomes are worse for women from disadvantaged, vulnerable or excluded groups. Country of birth data shows that the babies of mothers born in Pakistan had an infant mortality rate double the overall rate. Stillbirths and perinatal death rates were also significantly higher (*Health in London*, 2004).
- There are striking disparities between ethnic groups in terms of the numbers of workless households with dependent children, with one third of all of London's BME children living in a workless household compared to 19% of White children.
- There are significant differences in children's risk of being in a workless household between BME communities, with 11% of children of Indian ethnicity living in a workless household compared with 49% of children of mixed White and Black backgrounds.
- Among those aged under-25, unemployment was highest for the three Black groups (as recorded in the 2001 Census), with nearly one third of under 25s within each group being unemployed (*Health in London*, 2004).
- There are major differences in the educational attainment of different ethnic groups. In addition, native English speakers have higher attainment at each stage of school than those pupils registered as EAL (English as an additional language) which includes the majority of Indian, Pakistani, Bangladeshi and Chinese pupils in England (*Health in London*, 2004).
- Some ethnic groups are more likely to experience overcrowding in housing than others with, for example, Bangladeshi households more than five times more likely than White British households to be living in overcrowded conditions. Over half of Black African households, two fifths of Other Black households, and 38% of Pakistani households live in overcrowded conditions.
- In London, two thirds of Bangladeshi children and two thirds of Black African children were living in overcrowded housing, and rates for Mixed White and Black African, Pakistani, Other Asian and Other Black children were all over 40%.
- Ethnic minorities in Britain are at substantially increased risks of

burglary, vehicle crime and street crime (*Health in London*, 2004).

- There is currently a lack of data on the prevalence of some health issues within certain BME communities in London.
- Cigarette smoking in London is highest amongst Turkish, Bangladeshi and Irish men. Smoking rates are often, but not always, low among women in BME groups – for example only 1% of Bangladeshi women smoke (although one fifth use chewing tobacco) compared to up to 59% of Turkish women and 39% of Irish women.

Disabled children and young people

The 2003 *Health in London* report had a specific focus on the health of disabled people. As with the 2004 report, and much of the information in this the 2003 report is still current and many of its conclusions remain relevant. The full report can be found at <http://www.londonhealth.gov.uk/hinl2003.htm>

This year's *Health in London* report has not identified significant new information on disabled Londoners in relation to the indicators considered, which partly reflects the ongoing lack of reliable data on disability issues, particularly among children and young people.

However, the 2003 report highlighted that disabled Londoners fared worse on all the indicators for which relevant information was available, and a trawl of a wider range of information sources indicated that they fared worse in other dimensions too. In relation to children and young people, the 2003 report noted that there was a lack of data on the educational achievements of disabled children and limited information about disabled people's experience of

education, although one survey showed that 40 per cent of disabled people felt that teachers underestimated their ability.

Gender issues

There are differences in health-related behaviours and in health outcomes for boys and girls, although data are not available on some measures. However, some of the differences we are aware of include those summarised below:

- Life expectancy is higher in females than males
- Between the ages of 5-15 years, 19% of boys and 17% of girls eat five or more daily portions of fruit and vegetables, but in older young people (aged 16-24), more females (22%) eat the recommended five portions than males (19%)
- Rates of mental health disorders are higher among boys than girls in London, with rates among 11-15 year olds more than twice as high
- Rates of Chlamydia diagnoses have risen significantly over the last decade, with rates for girls aged 16-19 showing the steepest rate of increase
- In London there is a marked gender difference in smoking rates, with more secondary school girls aged 11-15 smoking than boys (11% and 7% respectively).

Implications for action

Planning children's services within the new structures and partnerships being developed under the ECM agenda should be better for children's well-being in the long term, with an increased focus on meeting needs and reducing inequalities right across the spectrum of services. However, in the shorter term, this makes for complex planning and relationship building, and the need to achieve multiple targets within and across organisations adds to the complexity of the situation.

In this section, we start by identifying overall recommendations for these strategic and partnership approaches to children and young people's health, before going on to identify additional opportunities for achieving change within specific types of service or intervention.

The London Health Commission and Mayor of London remain committed to influencing and co-ordinating partnership action on health at the regional level, and to supporting action at a local level. Local partnerships and leaders are also encouraged to consider ways in which they can take action to improve the health of London's children and young people and to reduce inequalities. In doing so, it is worth referring to the recommendations in previous *Health in London* reports as well as those described below; and in particular taking note of those related to ethnicity and disability highlighted in the reports which gave more detailed consideration to these areas.

Cross-cutting implications for action

Local councils, health and social care services, community and voluntary organisations and LSPs all have an important part to play in improving the well-being of children and young people

in London and in improving public health. A key challenge is to identify and make best use of the expertise, experience and opportunities each sector brings and to clearly demonstrate the relevance of the health agenda to their core business and responsibilities.

The cross-cutting implications for partnership action described below relate both to making best use of *structures and processes* for the planning and delivery of interventions, and ensuring the *content of programmes and interventions* is more appropriate and effective.

1. Listening effectively to children, young people and their parents.

What children and young people say about their health, their health services and their lives is evidence which is often undervalued and under-used. More consultations are taking place, but without use being made of the information and ideas generated, they risk provoking scepticism or cynicism in young citizens.

There have been a large number of consultations in London, some of which are referenced in this report, and **good use should be made of information and opinions already provided by children and young people.** In addition, there is likely to be benefit in a further study to synthesise some of the data from these, **and identify ways of tracking changes arising from consulting children.**

From April 2004, NHS Trusts have administered a parent survey and this will be followed by efforts to seek children's views directly. There is an opportunity to **refine performance management mechanisms to assess the whole loop – from seeking views, planning changes involving children, to making changes, monitoring them and**

seeking views on them from those affected. Incentives to act on what we learn from patients and users may be the most effective way to make sure that they are seen, heard, and responded to.

2. Tackling health inequalities

In planning, commissioning and delivering programmes for children and young people, there is a need to **focus on actions which will help reduce health inequalities in London** including:

- Investing in action to improve the determinants of health and not taking too narrow a 'lifestyle' approach
- Maximising opportunities to use Health Impact Assessment of wider policies and plans at local and regional levels to include a focus on the impact on children and young people; including, for example, planning for the Olympics
- Investigating further the key success factors in areas where good progress is being made relative to other areas
- monitoring and evaluating the effectiveness of both new and more established interventions, with a clear focus on routine collection of data on equalities dimensions, and ongoing involvement of children and young people.

3. Joint work between local authorities and primary care

Children and Young People's Plans (CYPPs) are being developed by local authorities with partners in *Children's Trusts*. Where the local authority is not responsible for a service whose work is included in the plan, the governance arrangements will need to be robust enough to ensure that the plan paints the full picture of how services are

working together to address outcomes for children and young people. The ability to **secure agreement to the widest possible scope for the CYPP and the necessary alignment with other plans** will be a key test of the effectiveness of *Children's Trusts*. Most authorities are expected to be working with partners through Children's Trusts by 2006, and all by 2008.

Joint planning with the Primary Care Trusts (PCTs) is crucial and PCTs' *Local Development Plans* should be consistent with the CYPP. The Public Health White Paper *Choosing health: making healthy choices easier* makes clear that the Government expects PCTs to be fully involved in the CYPP planning process.

One of the principles for local target setting in the *Health and Social Care Standards* and in *National Standards, Local Action* which sets out a planning framework for health and social care, is that **local primary care targets are developed in partnership with other NHS bodies and local authorities**. *National Standards, Local Action* also strongly endorses taking account of the needs of children and young people in local planning, and emphasises the **importance of considering National Service Frameworks (NSF), including the NSF for Children, Young People and Maternity Services, in local planning**. The NSF for children and young people is fully embedded in the outcomes framework developed for *Every Child Matters: Change for Children*, and the standards cannot be achieved without working with the local authority.

4. Supporting community involvement

The voluntary and community sectors (VCS) have a critical role in promoting child health and reducing health inequalities. Not only do many voluntary

Local planning for children and young people's services – some key features and opportunities for change

1. The NSF and the *Every Child Matters: Change for Children Programme* will provide opportunities for innovation and for the delivery of health care and health promotion in different settings. PCTs may wish to think in terms of what health input they can make to different settings, for example children's centres, extended schools, colleges or residential children's homes. The Strategic Health Authority (SHA) also has a role in shaping the CYPP. The *Teenage Pregnancy Strategy* is a good example of joint planning with the health service.
2. Arrangements will also need to be made to capture in CYPPs the key elements of the following plans, to ensure consistency with the strategies of other statutory partners:
 - a. The local police authority's *Three Year Strategy Plan* and local policing plan.
 - b. The statutory annual *Youth Justice Plan* prepared by the local multi-agency Youth Offending Team
 - c. The *Probation Area Annual Plan*, based on the *Business Plan of the National Probation Service for England and Wales*.
 - d. Crime and Disorder and Misuse of Drugs and Alcohol Strategies
3. *School Development Plans* will show how schools contribute to positive outcomes for children and young people. Schools are the only universal service all children have contact with most days of the week. Schools will play a key part in delivering services for children and young people, with their role in the prevention and protection agenda crucial to its success. They will need to work closely with *Children's Trusts* preparing and delivering the CYPP.
4. Other plans which need to be consistent with the CYPP are LSC local strategic plans for 14-19 education, the *Child and Adolescent Mental Health Strategies*, the *National Healthy Schools Programme* and play strategies. In addition, any planning documents on community safety, traffic, transport, culture, leisure, sports, open spaces, fire and rescue services and the wider public realm need to be taken into account insofar as they affect children and young people.

organisations have the specialist knowledge, skills and networks to reach communities and groups which find statutory bodies inaccessible, but services provided by the VCS are frequently perceived to be more inclusive and less stigmatising. Community-led responses to health issues can be very effective in meeting the health-related needs of different groups, as highlighted in the recent report on the VCS contribution to promoting mental health in BME communities (Mayor of London / African and Caribbean Mental Health Commission, April 2005).

In addition, previous *Health in London* reports highlighted the importance of **working with individuals and communities to understand different perspectives on health and illness**, and the recommendations in these reports remain relevant. The 2004 report identified the need for further work with London's BME communities to identify their own experience and expertise in dealing with health issues, increase our understanding of community-led responses to health issues, and to learn about culturally-determined approaches to improving health and responding to illness. The 2003 report pointed out the importance of working with disabled people, within the context of the social model of disability, to better understand and respond to their experience of health-related issues. Joint work with community-based organisations can increase the opportunities for this type of community engagement in health issues.

Despite the value offered by the community and voluntary sectors, however, VCS organisations frequently struggle for an equal status in planning and commissioning processes. Furthermore, many VCS organisations, especially the smaller ones, do not have the capacity to sustain their services in a

climate of short term funding and competitive tendering where price is the primary consideration. **London boroughs and NHS organisations need to individually and collectively review their working relationships with the VCS to ensure that the long term value they can offer is fully realised.**

5. Evidence-based policy and practice

The evidence base for effective public health policy and practice is growing and **all partners involved in developing and delivering children and young people's services should be encouraged and supported to make effective use of existing evidence.**

The incorporation of a Centre for Public Health Excellence into NICE in April 2004, and the work of the former Health Development Agency [http://www. publichealth.nice.org.uk/ page.aspx?o=home](http://www.publichealth.nice.org.uk/page.aspx?o=home) are supporting ongoing work to provide evidence based (or evidence informed) guidance. NICE is currently developing guidance on obesity, for instance, and the new guidance on depression in children will be helpful to those trying to improve mental health and emotional well-being (NICE, 2005). Recent LHO reports on smoking, sexual behaviour and nutrition, physical activity and obesity provide some suggestion of what may work, although we need more well-tested interventions to ensure that we are doing more good than harm.

The EPPI Centre at the University of London Institute of Education provides evidence-based reports in health promotion and education (see <http://eppi.ioe.ac.uk/EPPIWeb/home.aspx>) and the Child Health Research and Policy Unit at City University has a range of tools for practitioners wanting to use evidence, to access evidence summaries,

to assess how ready their organisation is to use research evidence, or to use a project planning tool to assist in planning which draws on research evidence. All of these can be found at www.whatworks-forchildren.org.uk

The data in this report provide ways in which local areas can have access to figures to enable them to benchmark progress. They add to the evidence base, and by demonstrating where things are going well, can help us to build on it. Differences across different parts of London and between diverse ethnic groups suggests that, as well as addressing problems, **we need to focus on what appears to be working well and identify approaches and interventions likely to support change in other settings.** To give an example from this report, Black African young people were the most positive of all groups about their health, followed by Indian young people.

6. Improving data and information on diverse communities

Routine NHS and local authority information systems do not enable us to look in sufficient detail at the differing prevalence of health and related needs in different communities across London. In addition, many data sets in public services use continue to be deficient in their attention to routinely collecting accurate information on equalities domains, including ethnicity and disability. And in spite of the mainstreaming of ethnicity monitoring in some settings, there are still few or no data on children's health from primary care sources, and ethnicity is still not recorded at birth and death registration.

Although there are some local analyses of health-related need (eg. based on health surveys or around individual general practices or hospitals), our

main sources of detailed information across London often have to be based on the most severe manifestation of illness or need, for example when people are admitted to hospital, or die, or when child protection procedures are initiated.

It is anticipated that the *Health in London* report series will, over time, produce important trend data for looking at changes that are happening in London. In addition, it is hoped that the planned London boost to the *Health Survey for England* will enable more data on lifestyle factors to be collected at borough level and below, and will enable trends to be monitored closely. Longitudinal studies such as *RELACHS* in East London provide an opportunity of understanding the health and health needs of minority ethnic populations living in disadvantage, and their value increases over time as they start to demonstrate where we are improving, and where we are doing less well.

However, **more attention needs to be given to building routine collection of equalities data into systems intended to monitor and evaluate services and other health interventions.** Previous *Health in London* reports considered the data needs in relation to race and disability in more detail and highlighted the importance of improving the evidence base in these areas. For example, the 2004 report on Race and Health recommended that:

- the statutory requirements associated with the *Race Relations (Amendment) Act 2000* should be used to provide a framework for and focus on increased monitoring and use of information about ethnicity

- ethnic categories should be defined as clearly and accurately as possible by those collecting information for research and service planning, enabling more focused approaches to establishing health needs and challenging health inequalities
- better links need to be established between qualitative and statistical information, at London-wide and local level.

The 2003 report on disability and health demonstrated the lack of even the most basic data in many areas related to impairment and disability. It highlighted the need for further data on the experience of disabled people in relation to the determinants of health and access to services.

In addition, this year's report demonstrates that we need to know more about the number and circumstances of vulnerable children and young people in relation to health, including those who are 'looked after', in prison or secure accommodation, and those with mental health issues. Looking on a case-by-case basis to learn what might be done differently in working with children at risk, much as currently happens in the Confidential Enquiries, may provide scope for learning and change.

We also need to know more about why some housing types, and some roads, some communities and some schools are apparently more accident prone than others. This may involve collecting data on near-accidents and averted accidents as well as the accidents which actually happen; and should include using what is already known more effectively.

Additional opportunities for action in specific service areas

Strategic change as outlined above should, in time, help partnerships to

achieve real improvement in front-line services and in the experience of children and young people living in different communities. Better collection, analysis and use of information can, and should, be used to influence decisions about resource allocations and service delivery, resulting in more effective targeting to improve the health of London's diverse communities, including those experiencing multiple deprivation.

In the remainder of this section, we highlight some additional opportunities to improve the health and well-being of London's children and young people through specific types of service and intervention. It is not intended that this be seen as an exhaustive list of areas or opportunities, rather as illustrative of the wide range of opportunities that exist for action at local levels.

7. Early years services/interventions

Reducing children's health inequalities starts with supporting parents. Parents who are healthy at the start of pregnancy generally have healthier babies. **Promoting better health for all, including those who may become parents**, is an effective way of reducing infant mortality in the long run. We need to focus on reducing smoking during pregnancy (and reducing children's exposure to second-hand smoke), improving the nutrition of women of child bearing age, providing high quality NHS services before, during and after birth and increasing breastfeeding initiation.

Infant mortality is influenced by a wide range of factors including ethnicity, socio-economic circumstances and access to appropriate health care. Higher than average mortality rates have been found in babies whose mothers were born outside England or Wales, young mothers, babies whose fathers were in

the routine and manual social class, sole-registered babies, and babies born in deprived areas. This illustrates the importance of not only focusing on health behaviours, but also **supporting interventions aimed at reducing poverty and increasing access to employment and opportunities for parents.**

8. Youth services

Both *Every Child Matters* and the recent *Youth Matters* green paper acknowledge the importance of play, recreation and leisure. **Being able to play freely and safely and having 'places to go and things to do'** consistently come up as top priorities for children and young people themselves. Adult policy makers and planners have not generally reflected these priorities and we have created an unsafe, unfriendly public space environment in too many settings for far too long.

Play and leisure not only promote physical health (more opportunities for activity being linked to obesity reduction) but are critical for promoting emotional health and well-being. Children in more deprived areas are particularly limited in their access to safe spaces and more attention needs to be given to **ensuring that provision is inclusive so that disabled children have equal access to independent play and leisure.** Work is already being developed through GLA guidance on developing local play strategies and the London Parks and Green Spaces Forum agenda, but this needs to be much higher up our agenda if we're genuine in our commitment to reflect the concerns of children and young people.

Much greater consideration must be given to the health of 14-19 year olds / teenagers who may have specific issues related to sexual health, teenage

pregnancy, crime and the fear of crime, mental health, nutrition, smoking, alcohol and drug use. In addition, evidence suggests that health behaviours that are laid down in adolescence are maintained into adulthood and influence lifelong health (Viner and Barker, 2005). Building an efficient health service for the future should include greater attention to securing adolescents' active engagement with their own health, but there is much to be done to achieve this goal.

The same age group is sometimes failed in the transition between children's and adult services and the most vulnerable of all, who may be leaving care, begin to feel the impact of yet more health damaging experiences such as unemployment or homelessness. More work is needed to **ensure that the "Growing up into adulthood" standard of the NSF is delivered** and that this group's specific needs are given more attention by all agencies not directly discussed in this report.

There are continuing concerns about the health and well-being of young people in the youth justice system with mental health and substance misuse problems being a particular concern. Work is already being undertaken under the auspices of the Youth Justice Board and there are links with the LHC development of an emotional well-being framework for children and young people in London. It will be important to **ensure that young offenders' needs are specifically addressed in these initiatives and that Youth Offending Teams are an integral part of the planning process.**

9. Education

Existing frameworks, such as *'Stand Up for Us'*, published by DfES can help to **improve the experience of young people in schools.** It covers

homophobic bullying, sex and relationships education and various measures to improve social inclusion. There is a need to continue to seek to better understand, build on and make use of information about why some children and young people are better able to benefit from education opportunities than others. For example, one factor which could be further explored is the experience of those who have succeeded in moving out of low attaining groups in education.

We know that one factor associated with doing well at school after a disadvantaged start in life is having a parent who takes an interest in a child's schooling. Current initiatives are already working to further promote this in London, and there is a need for **ongoing work to learn from and improve initiatives to support parents' engagement in their children's education**. The concept of lifelong learning clearly has implications for having an impact on employment, and given the importance of parental interest in a child's education in improving educational outcomes for children, may have an impact there too.

Attaining the National Healthy Schools Standard is an important goal for all schools by 2009. Understanding the mutual benefits of improving a child's health and education is an important aspect of the programme, and could lead to whole school and whole community approaches to child and family health. An important implication for action is for local stakeholders to get together to take action on promoting healthy eating in schools. The LHC *Healthy Young London* campaign has taken the lead on this by facilitating 'round table' events in four boroughs to identify opportunities and barriers to such joint initiatives.

10. Health and social care services

Access to interpreting and translation support is regularly highlighted as a major issue impacting on BME communities' access to services and information. Ongoing work to secure appropriate access to these services for BME communities is essential, and the LHC's Language Support Services Project is aiming to improve provision of services across public sector organisations, as well as increasing the employment opportunities these services offer within communities.

There is great scope to **reduce inequalities in the availability and experience of health services for children when they are ill**. Hospital admission rates have been falling in London and elsewhere. Hospitals are not the best places for ill children unless they need very specialist support. Given that going into hospital is disruptive for children, young people and families, opportunities are already being explored across London for different ways of looking after children when they are ill, and preventing the disruption to child and family life that happens when they are admitted. Further work is needed to explore the potential to further reduce hospital admissions.

For those children who do need to spend time in hospital, there are a number of issues which they have identified as needing attention to improve the hospital environment and the experience of children and families during hospital stays. There is some evidence that more progress has been made in listening to children than in responding to what they tell us (Curtis et al, 2004). Priorities for change among children and young people consulted in London in 2001-2 (Liabo et al, 2002) included:

- increasing the provision of age-appropriate facilities and resources
- providing continuity of care in both primary and secondary settings
- minimising problems and disruption associated with moving from child to adult services
- improving waiting facilities in Accident and Emergency departments to reduce exposure to others' illness or injury as well as violence, drunkenness and anti-social behaviour
- ensuring hospitals are accessible to disabled children
- increasing cleanliness in those hospitals where this continues to be a cause for concern.

In addition, **measures to safeguard children from abuse and exploitation** are integral to promoting current and longer-term health outcomes. Health organisations have a critical role in this and should be working alongside social services in both prevention and intervention. Services designed to support families not only have a role in preventing family difficulties but can also be part of overall strategies to promote health and well-being. Supporting parents is a crucial element of promoting the health of children. Ensuring that children and young people who are at risk of abuse or exploitation are identified and provided with appropriate support is a collective responsibility of all agencies. An example of the differential response between organisations and between boroughs was highlighted by a recent Barnardo's report on the needs of young people at risk of sexual exploitation across London (Harper & Scott, 2005).

It is essential that the health needs of children and young people requiring short- or longer-term care by local authorities are identified and met, with a focus on promoting continuity of health-related provision wherever possible. We know, for example, that children in care were five times more likely to have a mental disorder than other children and that many 'looked after' children have needs related to mental health (see Section 2 of this report for more detail). Work at both local and regional levels to plan and provide health service for London's children needs to take account of the specific needs of this group of Londoners.

11. Housing

Poor quality or temporary housing has implications for children's health in relation to accidents and infectious diseases and also for their emotional, behavioural and educational development. Temporary accommodation disrupts continuity of access to a wide variety of services, including primary health care. The number of families with dependent children and pregnant women in bed and breakfast accommodation in London has been falling, and this needs to be maintained.

There is much that still needs to be done to **maximise the health benefits known to be associated with good quality housing provision**. The London Health Commission has produced a briefing about opportunities to improve health through housing policy and practice (LHC, October 2005), supported by a web-based summary of evidence about health and housing conditions. A report from Health Bulletins Wales on Housing in 1998 lists (with evidence) a whole range of ways in which safety could be promoted through housing interventions <http://hebw.uwcm.ac.uk/healthyenvironments/Chapter11.html>

12. Planning and regeneration

Transport, environmental and play policies in London are likely to make at least as great a contribution to reducing deaths in London as the NHS. Urban planners are increasingly concerned with the safety of the built environment, green spaces and designing out crime. The Mayor's *London Plan* sets out a wide range of policies and proposals intended to improve the physical environment and quality of life in London. The Plan is supported by guidance intended to **support and influence planning-related activity in a wide range of key areas related to health** and more information on planning issues can be found at on the GLA website at <http://www.london.gov.uk/mayor/planning/key-documents.jsp>

One of the greatest opportunities for reducing deaths amongst less well off children is likely to lie with deaths from injury. Whilst motorists sometimes complain about being criminalised through speed cameras and speed limits, these are effective ways of preventing deaths. It is likely that the **20 mph zones** would be suitable for implementation over the majority of the borough road network and, if installed, would have the potential to make large casualty savings.

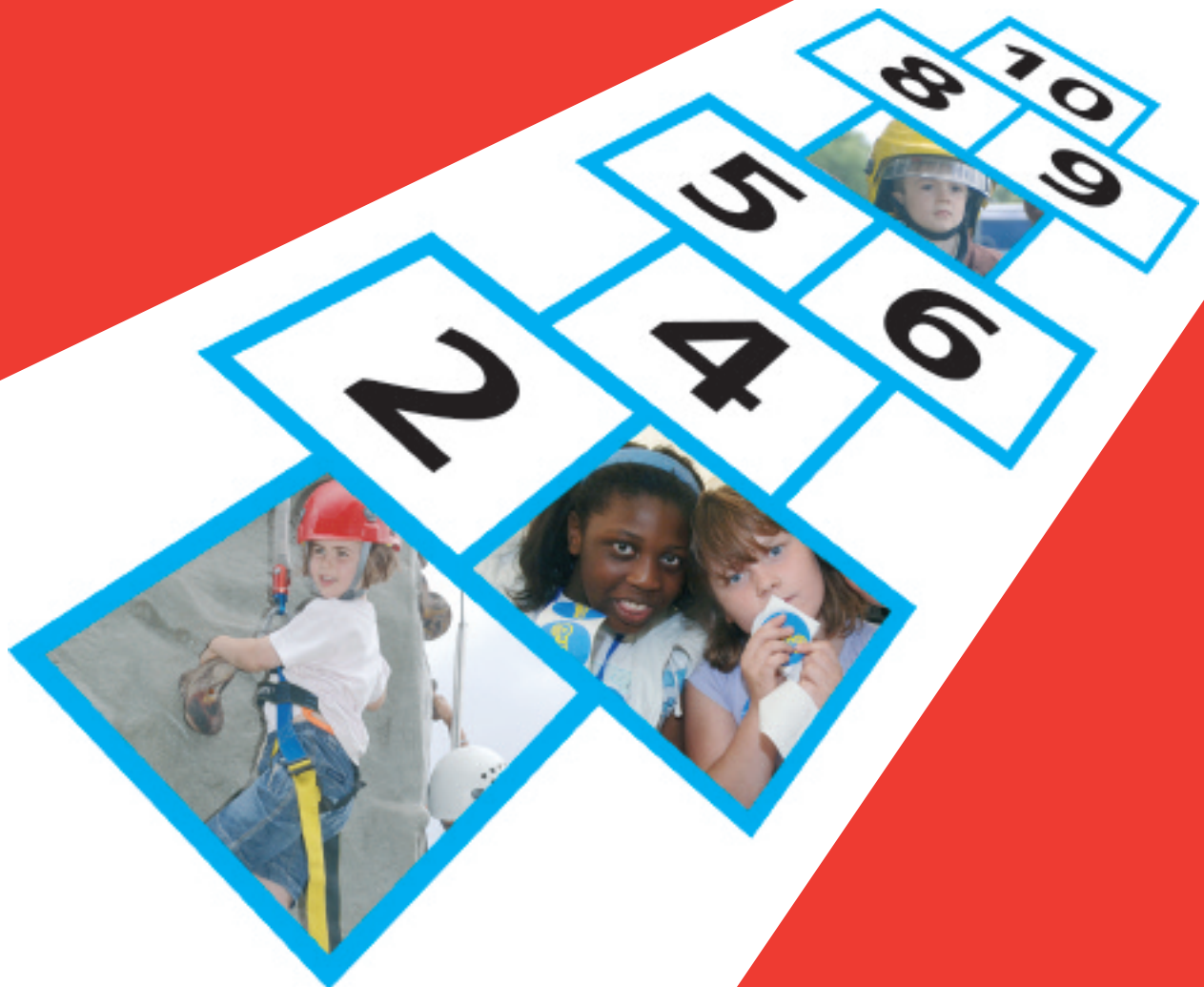
Moving to **air quality** and its effects on child health, there is work underway at regional level, including the Mayor's work to progress implementation of a Low Emission Zone which will limit the access of the most polluting lorries, buses and coaches to London's streets, and work to progress the Taxi Emissions Strategy, which will make all 20,000 London cabs meet the most stringent emission standard currently available. In addition, the Mayor continues to support and appraise the London boroughs' Local Air Quality Management work,

which identifies and addresses local pollution hotspots. (For a summary of this LAQM work see http://www.london.gov.uk/mayor/environment/air_quality/boros.jsp). For those wishing to monitor their local data, information can also be found at www.londonair.org.uk.

It is also **essential that planning and regeneration initiatives actively support ongoing work to improve access to employment for all**, including parents and carers. Good quality affordable childcare for those who want it, flexible working arrangements, wider access to educational opportunities for those parents who missed out on their education the first time round, and ensuring that young people can take employment and educational opportunities will provide a sound basis for eliminating child poverty by 2020. Initiatives such as the LDA's '*Diversity Works*' programme and the LHC's '*London Works for Better Health*' are seeking to address inequalities in access to employment and related opportunities.



Appendix



In this section...

Sources

Resources

Abbreviations

Glossary

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Resources

Useful websites

General

Democratic Health Network:
www.dhn.org.uk

Government Census 2001:
<http://www.statistics.gov.uk/census2001>

Health Development Agency:
www.hda.nhs.uk

London Health Observatory:
www.lho.org.uk

London Health reports:
www.londonhealth.gov.uk/hinl.htm

Public Health Excellence at NICE:
<http://www.publichealth.nice.org.uk/page.aspx?o=home>

Child Health Research and Policy Unit
(City University – a range of tools for practitioners wanting to use evidence or use a project planning tool that draws on research evidence):
www.whatworksforchildren.org.uk

Studies, programmes, reports, books

EPPI Centre (University of London Institute of Education - evidence-based reports in health promotion and education): <http://eppi.ioe.ac.uk/EPPIWeb/home.aspx>

Every Child Matters: Change for Children programme:
<http://www.everychildmatters.gov.uk/>

DASH study:
<http://www.msoc-mrc.gla.ac.uk/DASH/DASH-MAIN.html>

RELACHS study:
<http://www.ichs.qmul.ac.uk/relachs/>

and

RELACHS study (young people's version):
http://www.ichs.qmul.ac.uk/relachs/young_people/young_people_index.htm

Barnardo's What Works for Children series:
http://www.barnardos.org.uk/shop/publications/acatalog/What_Works_publications_series.html

Mental health

FOCUS (Royal College of Psychiatrists):
<http://www.focusproject.org.uk/default.asp>

National Self-Harm Network:
www.nshn.co.uk

The Young People and Self Harm information resource website:
www.selfharm.org.uk

Childline – a free and confidential telephone service for children:
www.childline.org.uk

The Samaritans – a 24-hour service offering confidential emotional support:
www.samaritans.org.uk

YoungMinds provides information and advice on child mental health issues:
www.youngminds.org.uk

'Changing Minds' – a CD-ROM designed for 13-17 year olds on mental health which looks at depression and self-harm:
www.rcpsych.ac.uk/publications/auvideo/cmindsacd/index.htm

Air pollution

Air quality and its effects on child health:

www.londonair.org.uk.

WHO's European regional priority goal to reduce children's exposure to air pollution:

<http://www.euro.who.int/child-healthenv/Risks/AirTop>

Local Air Quality Management work (identifies and addresses local pollution hotspots):

www.london.gov.uk/mayor/environment/air_quality/boros.jsp

Housing

Health Bulletins Wales on Housing – promoting safety through housing interventions:

<http://hebw.uwcm.ac.uk/healthyenvironments/Chapter11.html>

Abbreviations

A&E	Accident and Emergency
BMA	British Medical Association
BME	Black and Minority Ethnic
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CYPP	Children and Young People's Plan
DETR	(former) Department of the Environment, Transport and the Regions
DfES	Department for Education and Skills
DfT	Department for Transport
DH	Department of Health
DWP	Department of Work and Pensions
ECM	<i>Every Child Matters: Change for Children programme</i>
EU	European Union
GB	Great Britain
GCSE	General Certificate of Secondary Education
GDP	Gross Domestic Product
GLA	Greater London Authority
GNVQ	General National Vocational Qualification
GOL	Government Office for London
KS1 (2,3,4)	Key Stage 1 (2,3,4)
LAA	Local Area Agreement
LAEI	London Atmospheric Emissions Inventory
LEA	Local Education Authority
LFS	Labour Force Survey
LHC	London Health Commission
LHO	London Health Observatory
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NO ₂	Nitrogen dioxide
NO _x	Oxides of nitrogen
NSF	National Service Framework
OECD	Organisation for Economic Co-operation and Development
ODPM	Office of the Deputy Prime Minister
ONS	Office for National Statistics
PCT	Primary Care Trust
PM ₁₀	Fine particles (less than 10 microns in diameter)
RAS	Refugee and asylum seeking
TfL	Transport for London
UK	United Kingdom
WHO	World Health Organization

Glossary

Children and young people

An extensive definition of children and young people can be found in Section 1 of this report.

Deprived neighbourhoods

Local areas where the surveyor visually assessed whether any of the following problems apply:

- Over 10 per cent of buildings are seriously defective
- The presence of serious problems related to any of the following: Vacant sites or derelict buildings; vacant or boarded up buildings; litter, rubbish or dumping; vandalism; graffiti or scruffy buildings, gardens or landscaping; neglected buildings
- Very poor visual quality of the local area.

(See ODPM, 2003, for further details)

Disability

The loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers (Barnes, 2001).

Mean

The 'average', as used in its everyday sense, i.e. the sum of all the measurements, divided by the number of measurements.

Prevalence rate (crimes)

The percentage of households/persons who were victim of an offence once or more during the year. Unlike the incidence rate, it takes no account of the number of victimisations

experienced. (In the British Crime Survey, only persons aged 16+ are included).

Social class

Social class is commonly defined in terms of occupation. Until recently, government statistics used a five-fold hierarchical classification, based on occupational skill:

Non-manual

- I Professional occupations, e.g. accountants, doctors, engineers
- II Managerial and technical occupations, e.g. marketing and sales managers, teachers
- IIIN Skilled occupations – non-manual, e.g. clerks, cashiers

Manual

- IIIM Skilled occupations – manual, e.g. carpenters, joiners, manual foremen
- IV Partly skilled occupations, e.g. security guards, warehousemen
- V Unskilled occupations, e.g. labourers, cleaners

In 2001, the government introduced the new National Statistics Socio-economic Classification (NS-SEC). This takes account of social changes, and is based not on skill levels but on employment relations and conditions. The new NS-SEC classification is shown below:

- 1 Higher managerial and professional occupations

2. Lower managerial and professional occupations
3. Intermediate occupations
4. Small employers and own account workers
5. Lower supervisory and technical occupations
6. Semi-routine occupations
7. Routine occupations
8. Never worked and long-term unemployed.

'Intermediate' includes, for example, mid-level administrative, technical and sales occupations.

There is broad continuity with the old classifications, which will facilitate comparison with the past.

This report uses both classifications listed above. However, the report also uses 'social class' in a more general sense, to describe groups at different economic or occupational levels; a number of classifications have been used in the research quoted here, some of which was based in other countries.

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